

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11343

Items #1a & 2a Film #G392 9/1/67 ph

CERTIFICATE OF DEATH

11347

1. PLACE OF DEATH Prince George's a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>3 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1215 Kirklynn Ave.</u>				d. STREET ADDRESS <u>1213 Kirklynn Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nels Peter Alifas</u> First Middle Last				4. DATE OF DEATH <u>August 25</u> 1967 Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 17, 1879</u> Yrs. Months Days	
9. AGE (In years last birthday) <u>88</u> Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Alifas</u>				14. MOTHER'S MAIDEN NAME <u>Sophia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-6318a</u>		17. INFORMANT <u>Mrs. Bernice Simms</u> Address <u>1215 Kirklynn Ave. Jk. Pk. Md.</u> <u>Daughter</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma Prostate with</u> DUE TO <u>extension into urinary bladder</u> (c) <u>extension into urinary bladder</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 8</u> , 19 <u>57</u> , to <u>Aug 25</u> , 1967, that (I) (we) last saw the deceased alive on <u>Aug 22</u> , 1967, and that death occurred at <u>11:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Richard J. Whelton</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard Whelton</u>				22d. ADDRESS <u>1017 Univ. Blvd. E. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Snitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey Inc.</u>				25a. REC'D BY REGISTRAR <u>Aug 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1111

THE HOUSE OF REPRESENTATIVES

1877



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11348

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Muirkirk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Admiral Anderson		4. DATE OF DEATH Month 8 Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 May 1907
9. AGE (In years lost birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Major Anderson		14. MOTHER'S MAIDEN NAME Sadie Crump	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Oscar Crump		Address 7604 Muirkirk Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —			INTERVAL BETWEEN ONSET AND DEATH minutes over 8 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 8-15-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) —	23b. DATE THEREOF 8-19-67	23c. NAME OF CEMETERY OR CREMATORY Queens Chapel	23d. LOCATION (City or Town) (County) (State) Muirkirk, Md
24. FUNERAL DIRECTOR H.S. Washington & Sons		25. REC'D BY REGISTRAR DATE AUG 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343

11343



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11347

11349

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 26 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol		d. STREET ADDRESS ----	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Russell Harrison Anderson		4. DATE OF DEATH Month Day Year August 1 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/87
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Anderson		14. MOTHER'S MAIDEN NAME Mary Dowell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Harry Anderson-		Address Deale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593x Chemia DUE TO Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Renal failure DUE TO (c) Renal failure		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CVA. (Cerebral Vascular Accident)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 67 , to 8/1 , 19 67 , that (I) (we) lost the deceased alive on 8/1 , 19 67 , and that death occurred at 5:30M , from causes and on the date stated above.			
22a. SIGNATURE A. Clark Holmes		22b. DATE SIGNED 8/2/67	
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M. D.		22d. ADDRESS Upper Marlboro, Md. 20870	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR AUG 14 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

Historic Boro, Upper Marlboro, Md.

8/25/57

W. Lincoln Cemetery, Hagerstown

A. Clark Holmes, M. D., Upper Marlboro, Md. 20870

No. --

Thomas Anderson

Mary Powell

Tobacco Farming Own Farm

Maryland

U. S. A.

X

11346 Item #23c & d Film #03918/10/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11350

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Mass. ESSEX		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Lynn. Zip 01902	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 48 Prospect Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lonnie Mack Andrews			4. DATE OF DEATH Month 8 Day 3 Year 1967		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) 32 yrs.		9. IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Car Body Shop		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Louis Andrews		
14. MOTHER'S MAIDEN NAME Rosa Mitchell			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES KORRAN		
16. SOCIAL SECURITY NO. 250 585055			17. INFORMANT Mrs. Margot E. Andrews Same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Contusion of brain DUE TO Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Grand mal epilepsy since childhood.					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ing wall. Driver of car which went out of control and hit a retain-		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:15am p.m. 8-2- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9600 block Baltimore Ave., College Park, Md.	
20f. (City or town) (County) (State) West Lynn, Essex, Mass.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22. DATE SIGNED 8-3-67			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county) W. W. CHAMBERS CO. Riverdale, Md.			23d. LOCATION (City or Town) (County) (State) Greenwood, South Carolina		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug. 7, 1967		
23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery			23d. LOCATION (City or Town) (County) (State) Lynn, Massachusetts		
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. Riverdale, Md.			25a. REC'D BY REGISTRAR AUG 8 1967		
25b. REGISTRAR'S SIGNATURE Charles Judge			25c. REGISTRAR'S SIGNATURE Charles Judge		

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

2

per 1000 10000

2012-01-01

4. 25 5000

[illegible]

— — — — —

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11349

11351

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boulevard Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4157 Southern Ave.,		16-1	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Rhodes Andrews				4. DATE OF DEATH Month Day Year 8 27 19 67			
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 May 1911		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Columbus Rhodes				14. MOTHER'S MAIDEN NAME Sudie ???			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Angela Andrews 4157 Southern Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) unknown							INTERVAL BETWEEN DEATH AND AUTOPSY Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus-over 10 yrs.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 8-27-67
ACTUAL SIGNATURE John Kehoe, M.D.,		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Riverdale					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Homewood Cemetery		23d. LOCATION (City or Town) (County) (State) Homestead, Pa.	
24. FUNERAL DIRECTOR Charles Judge		ADDRESS 4001 Benning Rd. N.E.		25a. REC'D BY REGISTRAR SEP 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

99

2

2

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

11821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11352

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 2903 Allison St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert J. Ballantyne Sr.		4. DATE OF DEATH Month Aug. Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/97
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY C.F.&B. Const.Co. Baltimore, Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Hamilton Ballantyne		14. MOTHER'S MAIDEN NAME Mary Yeakle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 721-18-6234	
17. INFORMANT Mrs. Louise K. Ballantyne (above add-ress)		Address (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Meningitis DUE TO (b) Septicemia DUE TO (c) 340.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Aug 27 , 19 67 , to Aug. 3 , 19 67 that (I) (the hospital) saw the deceased alive on Aug. 3 , 19 67 , and that death occurred at 4:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Irvin Grassgreen		22b. DATE SIGNED 8-4-67	
22c. PHYSICIAN'S NAME (Type) Irvin Grassgreen, M. D.		22d. ADDRESS 3101 Arundel Rd. Mt. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-7-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR Mally		25a. REC'D BY REGISTRAR DATE AUG 9 1967	
ADDRESS Mt Rainier Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

1155

STATEMENT OF DEBIT

Account of

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

Dr. R. R. R. R.

CERTIFICATE OF DEATH

11351

11353

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY <u>PRIN. Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. DC.</u> b. COUNTY <u>47-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>Elizabeth I Barnes</u>		Month Day Year <u>Aug. 7, 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
		<u>2-22-87</u>	9. AGE (In years last birthday) yrs. <u>80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife at home</u>		<u>Alatama</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Alabama</u>		<u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Graciel F. Ingram</u>		<u>Lueretta D. Hendricks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>			
17. INFORMANT		Address	
<u>Gene Traftand</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V.D</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebrovascular Accident</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> , 19 <u>67</u> , to <u>8-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-7</u> , 19 <u>67</u> , and that death occurred at <u>8:15 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Rumara</u>		22b. DATE SIGNED <u>8-7-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
		<u>Pine View Gardens</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>8.10.67</u>	<u>Cedar Hill Cemetery</u>	<u>Washington D.C.</u>
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
<u>LEE FUNERAL HOME 3064 ST NE</u>		<u>AUG 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

27.11

CERTIFICATE OF DEATH

27.11



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

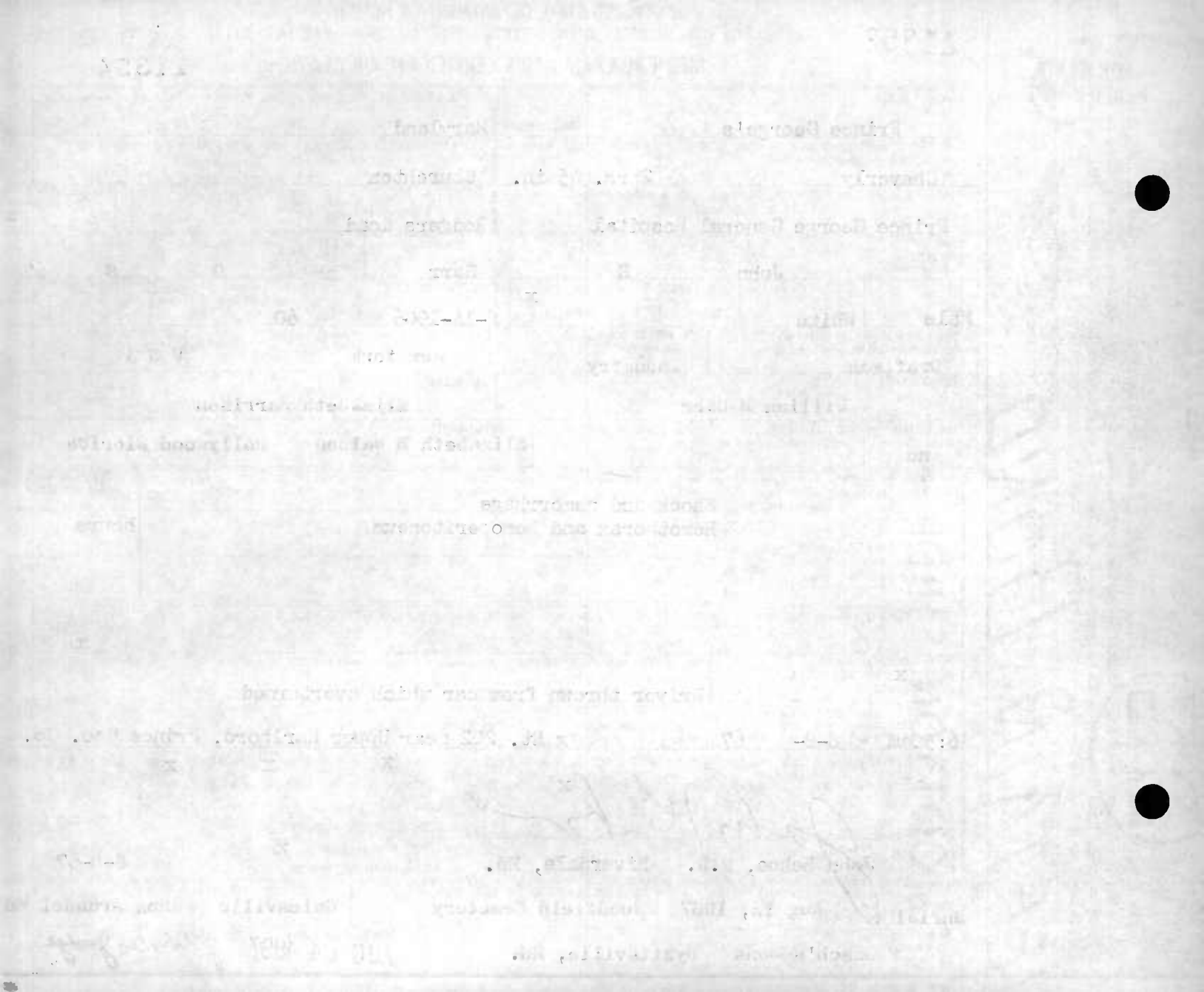
11354

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2hrs. 45min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		d. STREET ADDRESS Rodgers Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John E. Barr		4. DATE OF DEATH Month 8 Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1906
9. AGE (In years lost birthday) yrs. 60		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftman		10b. KIND OF BUSINESS OR INDUSTRY Industry	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H Barr		14. MOTHER'S MAIDEN NAME Elizabeth Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Elizabeth B Walden		Address Hollywood Florida	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and hemorrhage DUE TO Hemothorax and hemoperitoneum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver thrown from car which overturned	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:50am p.m. 8-8- 19 67		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Rt. 202 near Upper Marlboro, Prince Geo. Co.	
20f. (City or town) (County) (State) Prince Geo. Co.		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 8-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		23. LOCATION (City or Town) (County) (State) Galesville Anna Arundel Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY Woodfield Cemetery		23d. ADDRESS F Gasch's Sons Hyattsville, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR AUG 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11355											
Item #9 Film #G392 9/25/67 ph											
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P. G.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>607 Haynes Road</u>						d. STREET ADDRESS <u>607 Haynes Rd</u>					
3. NAME OF DECEASED (Type or print) <u>ANNA STATIA</u> First Middle Last						4. DATE OF DEATH <u>Aug 28</u> 19 <u>67</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7, 1896</u>		9. AGE (In years, last birthday) <u>70 11</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles McIntyre</u>						14. MOTHER'S MAIDEN NAME <u>Mary Clair Doyle</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>						16. SOCIAL SECURITY NO. <u>212-20-1804</u>		17. INFORMANT <u>Mr. Alfred Lepore Jr.</u> Address <u>1310 2nd St Laurel Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>C.V.A. Stroke</u>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>331X</u> DUE TO <u>Hypertension and generalized Cerebral Arteriosclerosis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Diabetes Mellitus</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>8/28</u> , 19 <u>67</u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>J M Warren</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>J M WARREN</u>						22d. ADDRESS <u>LAUREL, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/31/67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cem</u>			23d. LOCATION (City, town or county) (State) <u>Laurel Md</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witt Canalehan</u>						ADDRESS <u>Laurel Md</u>			25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>		
						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

11552

11552

11552

THE LIBRARY OF THE
MUSEUM OF NATURAL HISTORY
AND
ZOOLOGY
100 SOUTH GUYENNE STREET
LOS ANGELES, CALIF. 90007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11354					11356				
CERTIFICATE OF DEATH					11356				
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 16.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 5516 Volta Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Gerald John Bergmeier					4. DATE OF DEATH Month Aug. Day 24 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1908		9. AGE (In years last birthday) yrs. 59 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10b. KIND OF BUSINESS OR INDUSTRY Electronics		11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Conrad Bergmeier					14. MOTHER'S MAIDEN NAME Crecenze Fiendler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 094672637		17. INFORMANT Address Mabel C Bergmeier Bladensburg, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus DUE TO Cerebrovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (we) attended the deceased from 4-2 , 19 06 , to Aug. 24 , 19 67 , that (I) (we) saw the deceased alive on 8-20 19 67 , and that death occurred at 7:04 P.M. from causes and on the date stated above.									
22a. SIGNATURE Aaron Deitz					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-26-67		
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.					22d. ADDRESS Prince George's Plaza, Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE AUG 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

11-22-33

UNITED STATES OF AMERICA

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records General Hospital

3515 Volta Avenue

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Aug. 24, 1933

7:00

Prison Records

Prison Records

Prison Records

Prison Records

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11355

11357

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) clinton		c. LENGTH OF STAY IN lb 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Maryland General Hospital		d. STREET ADDRESS Waldorf, Maryland	
3. NAME OF DECEASED (Type or print) Lillian V. Berry		4. DATE OF DEATH Month 8 Day 14 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-86
9. AGE (In years lost birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN N. ROBEY		14. MOTHER'S MAIDEN NAME MARY C. TURNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-56-0672	
17. INFORMANT MARGARET DODSON, WALDORF, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Visceral Failure DUE TO (b) Bleeding Peptic Ulcer DUE TO (c) Pneumonia, Azotemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca. of Breast, Ca. of Colon		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 to Dec , 19 67 , that (I) (we) last saw the deceased alive on 8/14 19 67 , and that death occurred at 9:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert W. Merkle MD		22b. DATE SIGNED 8/14/67	
22c. PHYSICIAN'S NAME (Type) Robert W. Merkle, M.D.		22d. ADDRESS Clinton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-18-67	
23c. NAME OF CEMETERY OR CREMATORY ST PETERS CEM.		23d. LOCATION (City or Town) (County) (State) WALDORF, CHARLES, MD.	
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR AUG 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1957

RECEIVED BY MAIL

1957

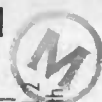
1957

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11358

11358

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>FAIRFAX, Va.</u> b. COUNTY <u>833</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. LENGTH OF STAY IN lb <u>48 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairfax, Va.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing & Rehabilitation Center 215 N. Fairfax</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leu</u> Middle <u>D.</u> Last <u>Bertram</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>1967</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1890</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Ransom</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jew W. Duncan</u>				14. MOTHER'S MAIDEN NAME <u>ANN MAY Keyser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>VA</u> <u>Mrs. B. K. Haffney, Alexandria</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO (b) <u>Arteriosclerotic Cerebrovascular Disease</u> stating the underlying cause last. DUE TO (c) <u>E</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pt. had a C.V.A. June 3 1967 & aphasia & right hemiparesis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from <u>7/10/67</u> to <u>8/24/67</u> , that (I) we last saw the deceased alive on <u>8/24/67</u> , and that death occurred at <u>2:08 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Relvin L. Minchin, M.D.</u>				22b. DATE SIGNED <u>8/24/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RELVIN L. MINCHIN</u>				22d. ADDRESS <u>6600 MARLBORO PIKE SE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>8-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematorium</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Remain Funeral Home, Alexandria, Va.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 28 1967</u>							

1958

2522

100

TO THE DIRECTOR, UNIVERSITY OF CHICAGO

FROM THE DEPARTMENT OF CHEMISTRY

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11357		11359	
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u>	c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>4808 GUILFORD ROAD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES R BOEHMAN</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3 1898</u>
9. AGE (In years lost, birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sell Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store Owner</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis Ryland (deceased)</u>	
14. MOTHER'S MAIDEN NAME <u>Mary H. Hall (deceased)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>578 05 0885</u>		17. INFORMANT <u>4808 Guilford Rd. College Pk. Md.</u> <u>Roberta M. Boehman (wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Intermittent</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>ONE</u> <u>month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the deceased) attended the deceased from <u>JULY 25, 1967</u> , to <u>AUG 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>AUG 22, 1967</u> , and that death occurred at <u>14:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Paul A. DeVore</u>		22b. DATE SIGNED <u>Aug 23 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul A. DeVore, M.D.</u>		22d. ADDRESS <u>3415 Hamilton St Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pr. Geo. Md.</u>
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 28 1967</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

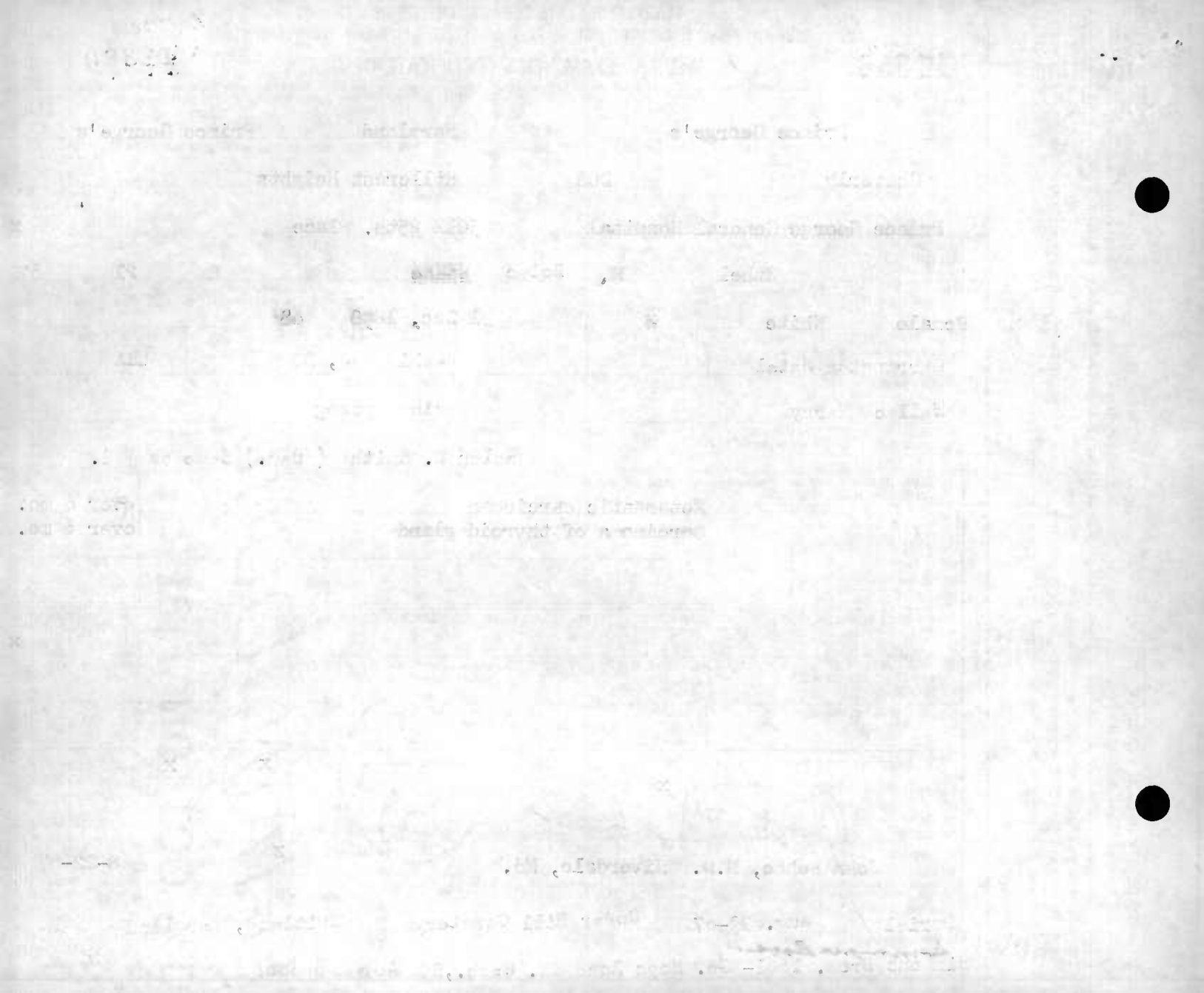
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11358

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11360

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel M. Bolac		4. DATE OF DEATH Month 8 Day 21 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Dec, 1898
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Harrington Hotel		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallace Harry		14. MOTHER'S MAIDEN NAME Bertha Wysong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Helen D. Smith (Dau.)		Address Same as # 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 194X IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Carcinoma of thyroid gland Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH over 6 mo. over 6 mo.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 8-22-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 23-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR AUG 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



11350

CERTIFICATE OF DEATH

11362

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 1 hr. 10 mins d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 3129 Parkway Terrace Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry F. -- Bradley 3rd 4. DATE OF DEATH Month Day Year August 18, 1967				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 13, 1966 9. AGE (In years last birthday) XXXXXX 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry F. Bradley 2nd. 14. MOTHER'S MAIDEN NAME Carol Lee XXXXXXX Register 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Carol Lee Bradley (Mother) #2.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 acute heart failure DUE TO (b) cardiomegaly marked (Etol. pending) DUE TO (c) microscopic examination CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (this hospital) attended the deceased from Aug. 18, 1967 , to Aug. 18, 1967 , that (we) last saw the deceased alive on Aug. 18, 1967 , and that death occurred at 12:10M , from causes on and on the date stated above.			
22a. SIGNATURE Harold Y. Finck 22c. PHYSICIAN'S NAME (Type) Harold Y. Finck 22b. DATE SIGNED PM M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Prince Georges General Hospital				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF August 19, 67 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery 23d. LOCATION (City or Town) (County) (State) Clinton, Maryland 24. FUNERAL DIRECTOR Simmons Brothers ADDRESS Simmons Brothers 1661- Gd. Hope Rd. SE. DC. 25a. REC'D BY REGISTRAR DATE AUG 21 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Prince Georges

17-10-1944

General

17-10-1944

Prince Georges General Hospital

17-10-1944

Unit

17-10-1944

Unit

17-10-1944

17-10-1944

17-10-1944

17-10-1944

17-10-1944

17

17-10-1944

17-10-1944

17-10-1944

17-10-1944

CERTIFICATE OF DEATH

11360

11363

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louise Braxton		4. DATE OF DEATH Month Day Year Aug. 30, 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1909 9. AGE (In years lost birth day) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Hawkins		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 401.0 IMMEDIATE CAUSE (a) Uremia, secondary to Chronic Glomerulonephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Fribrinous Pericarditis (Uremic Pericarditis) DUE TO (c) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that xx (this hospital) attended the deceased from Aug. 25, 19 67 to Aug. 30, 19 67 , that xx (we) last saw the deceased alive on Aug. 30, 1967 , and that death occurred at 8:55 A. from causes and on the date stated above.			
22a. SIGNATURE <i>Edwin Jensen</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edwin Jensen, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-2-67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City or Town) (County) (State) Landover, P.G. Co., Md.
24. FUNERAL DIRECTOR HALL BROS. 621 FIA AVE. N.W.		25a. RECD BY REGISTRAR SEP 5 1967 DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1433

REPORT OF DEATH

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

11361

CERTIFICATE OF DEATH

11364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Esther H Brockdorff</u>		4. DATE OF DEATH Month Day Year <u>August 28 1967</u>	
5. SEX <u>f.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/1883</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Copenhagen Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Aage Henriksen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Calvin Brockdorff</u>		Address <u>8508 - 16th Street Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest (Heart Block)</u> <u>4330</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Auricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Fractured left hip July 1967</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>Undetermined</u> <u>Undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Cerebral Thromboses (Multiple) 1966-1967</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1967</u> to <u>Aug 28, 1967</u> that (I) (we) last saw the deceased alive on <u>Aug 27, 1967</u> , and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>George L. Ball</u>		22b. DATE SIGNED <u>Aug 28, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		22d. ADDRESS <u>10620 Georgia Ave Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 31, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

100

11362

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale Hospital (rural)		c. LENGTH OF STAY IN lb 10 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS No fixed address	
3. NAME OF DECEASED (Type or print) Bernard S. Brown		4. DATE OF DEATH Month 8 Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1923
9. AGE (In years lost birthday) yrs. 43		IF UNDER 1 YEAR Months 1 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Nelson City, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Massie Brown		14. MOTHER'S MAIDEN NAME Annie Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-12-5257	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pulmonary tuberculosis (c) 8 years			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. Month, Day, Year 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that it (this hospital) attended the deceased from 10/5 , 1966 to 8/1/1967 , that it (we) lost saw the deceased alive on 8/1 19 67 , and that death occurred at 5:10 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 8/1/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-9-67	23c. NAME OF CEMETERY OR CREMATORY Harmony mem	23d. LOCATION (City or Town) (County) (State) Landover Md.
24. FUNERAL DIRECTOR Universal Funeral Home 816 H. St. N.E.		25a. REC'D BY REGISTRAR DATE 8-9-67 AUG 14 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

1000

OFFICE OF THE

1000

OFFICE OF THE

OFFICE OF THE

OFFICE OF THE

OFFICE OF THE

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>Item 18 Film 392 8-30-67</div> <div> <div>11363</div> <div>Item #9 Film #G392 8/28/67 ph</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>11366</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <i>PR. Georges</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Pro Geo.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood, Ind</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pr. Georges Gen. Hospital.</i>						d. STREET ADDRESS <i>3717 Quincy st</i>				16-1	
3. NAME OF DECEASED (Type or print) <i>GRACE</i> First Middle Last <i>O Brown.</i>						4. DATE OF DEATH Month <i>Aug</i> Day <i>20</i> Year <i>1967</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Oct 24, 1904</i>		9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Auditor</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Charlottesville, Va</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Andrew Omohundro</i>						14. MOTHER'S MAIDEN NAME <i>Brockenbrough</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hoyt Brown</i> Address <i>Brentwood Ind</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tumor of Rt. Kidney</i> (b) <i>(1st 1/2 of tumor / will / be / determined / by / pathologist / exam.)</i> (c) <i>massive G. I tract bleeding</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>JUNE 25, 1967</i> , to <i>AUG 20 1967</i> that (I) (we) last saw the deceased alive on <i>AUG. 19 1967</i> , and that death occurred at <i>11 AM</i> , from causes and on the date stated above.											
22a. SIGNATURE <i>Don B. Cameron</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8-20-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>DON B. CAMERON</i>						22d. ADDRESS <i>3503 PERRY ST MT. RAINIER</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 23, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Washington D. C.</i>			
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>						25a. REC'D BY REGISTRAR <i>DATE AUG 23 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1913

THE UNIVERSITY OF CHICAGO PRESS

1913

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwritten text at the bottom of the page.]

[Faint, illegible handwritten text at the bottom of the page.]

11367

11364

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN lb 3 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS Box 3650 TANYALD Rd	
3. NAME OF DECEASED (Type or print) ALICE NADINE BURCH		4. DATE OF DEATH Aug 2 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 JUNE 1907
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) HOANAKER, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT W. MEADE		14. MOTHER'S MAIDEN NAME MELLISIA LOCKHART	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-03-7634	
17. INFORMANT William A. Burch		Address HUSBAND SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA & ACUTE RESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYELOGENOUS DUE TO (c) LEUKEMIA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) XXXX STATUS POST SPLENECTOMY FOR SPONTANEOUS RUPTURE			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 30 July , 19 67 , to 2 Aug , 19 67 , that (we) last saw the deceased alive on 2 August 19 67 , and that death occurred at 12:00 PM from causes and on the date stated above.			
22a. SIGNATURE John F. Lindeman		22b. DATE SIGNED 2 Aug 67	
22c. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT, USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-5-67	23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial	23d. LOCATION (City or Town) (County) (State) Waldorf Chas. Md.
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR Aug 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1101

CERTIFICATE OF DEATH

PRINCE GEORGE'S COUNTY, MARYLAND

ANDREW A. 5 DAYS

USAT HOSPITAL ANDREW A. Box 3650 FAYAL RD.

ALICE MARY BURCH

EMMA'S CAR TO JOHN A. 30

ROBERT A. MESSER ROBERT A. VIRGINIA USA

ROBERT A. MESSER KELLIE'S LOOKHART

NO 1990-20-3880 HUSBAND JOHN A. 30

PNEUMONIA & ACUTE RESPIRATORY FAILURE

ACUTE PNEUMONIA

LEONARD

JOHN STATUS POST PNEUMONIA FOR SPONTANEOUS RUPTURE

30 July 1951

11:00 PM

USAT Hospital Andrews

JOHN F. LINDEMAN, COPT USAF MC

USAT Hospital Andrews Box 3650 FAYAL RD.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR-STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 349 Irvington Street	
3. NAME OF DECEASED (Type or print) Samuel P. Burnette		4. DATE OF DEATH Month 8 Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 April 1905
9. AGE (In years lost birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		10b. KIND OF BUSINESS OR INDUSTRY Merkle Press	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel P. Burnette		14. MOTHER'S MAIDEN NAME Anna C. Helton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Cecelia E. Burnette (Wife)		Address Same as # 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis cerebellar artery DUE TO And congestive heart failure (b) From myocardial fibrosis and infarction DUE TO From coronary arteriosclerotic heart disease (c) 		INTERVAL BETWEEN ONSET AND DEATH hours years years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 8-16-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 18-1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland.	
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC	
25a. REC'D BY REGISTRAR AUG 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100
100-100 100-100 100-100
100-100 100-100 100-100
100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

100-100 100-100 100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11366

CERTIFICATE OF DEATH

11369

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1-1/2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS 7329 Branch Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) George G. Butler			4. DATE OF DEATH Month August Day 22 Year 1967		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/11	9. AGE (In years last birthday) yrs. 56	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant			10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Gwynnie Butler		
14. MOTHER'S MAIDEN NAME Rosie Proctor			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Mrs. Edna L. Butler - Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 CONGESTIVE HEART FAILURE DUE TO (b) COR PULMONACE DUE TO (c) EMPHYSEMA					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 21, 1967 to Aug. 22, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Aug. 22, 1967 , and that death occurred at 11:43M , from causes and on the date stated above.					
22a. SIGNATURE Roger M. Ingham			22b. DATE SIGNED Aug. 23, 1967		
22c. PHYSICIAN'S NAME (Type) Roger Ingham, M. D.			22d. ADDRESS Prince Georges General Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-26-67		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	
23d. LOCATION (City or Town) (County) (State) Clinton, Maryland		24. FUNERAL DIRECTOR John T. Rhines Co			
25a. REC'D BY REGISTRAR DATE AUG 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

1-6-57

STATE OF TEXAS

1-6-57

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

11370

11367

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1375 Morris Rd., S.E.	
3. NAME OF DECEASED (Type or print) Mable G. Butler		4. DATE OF DEATH Month Aug. Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/98
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-20-0136	
17. INFORMANT Decedent		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Recurrent Cerebrovascular Accidents DUE TO (c) Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/24/ 1967 , to 8/25/ 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 8/25 19 67 , and that death occurred on 1:30PM , from causes on and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 8-25-67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Aug 31 1967		23b. DATE THEREOF Aug 31 1967	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION (City or Town) (County) (State) Suitland Rd. Md.	
24. FUNERAL DIRECTOR William F. M. G. R. U. D. E. A. 2311 Nichols Ave S.E.		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Prince Georges

W.D.

Glenn Dale (trial)

35 days

Washington

Glenn Dale Hospital

1375 Morris Ave., N.Y.

Male

D.

Parier

Aug.

Female

W-pro

8/20/98

82

Domestic

Marriage

USA

Unknown

Unknown

No

378-20-0138

Independent

K

Glenn Dale Hospital
Glenn Dale, Maryland

Max Gales, M.D.

AUG 2 1961

FOR STATE
HEALTH DEPT

11368

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11371

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

99

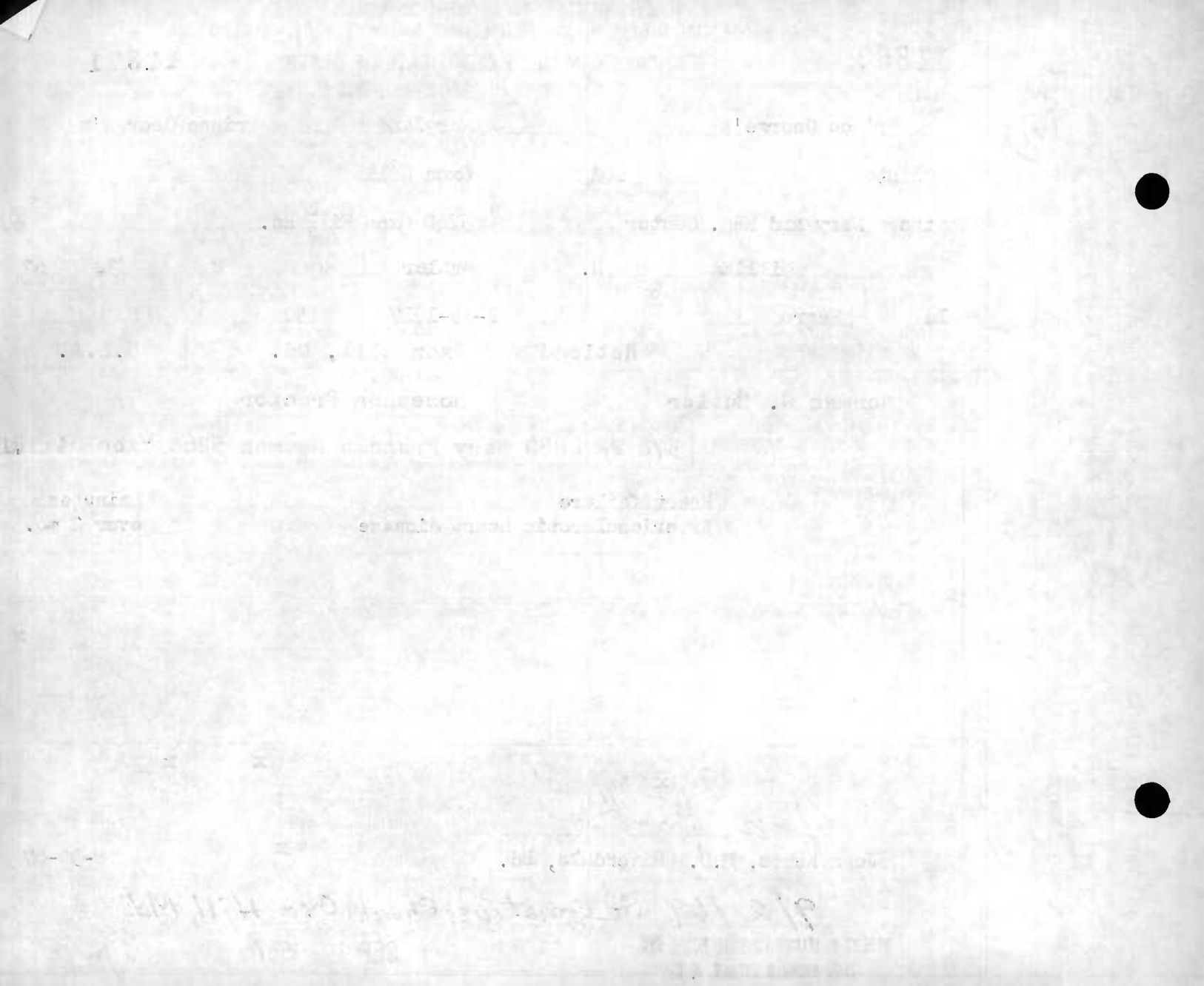
I

2

2

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Maryland Med. Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William H. Butler		4. DATE OF DEATH Month 8 Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1917
9. AGE (In years lost birthday) yrs. 50		10. IF UNDER 1 YEAR Months Days Hours Min. 30 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Oxon Hill, Md.	
13. FATHER'S NAME Norman G. Butler		12. CITIZEN OF WHAT COUNTRY U.S.A.	
14. MOTHER'S MAIDEN NAME Roseanna Proctor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 578 22 4880		17. INFORMANT Mary Frances Newman Address 5260 Oxon Hill Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/2 1967	
24. FUNERAL DIRECTOR ROBERT G. MASON FUNERAL HOME, INC.		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Church	
25a. REC'D BY REGISTRAR SEP 1 1967		23d. LOCATION (City or Town) (County) (State) Oxon Hill, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 8-30-67	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11369

CERTIFICATE OF DEATH

11372

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland		c. LENGTH OF STAY IN lb 18 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Maryland		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4709 Berwyn Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Geneva Pearl Caldwell		4. DATE OF DEATH Month Day Year 8 14 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/88
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Craig County, Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Caldwell		14. MOTHER'S MAIDEN NAME Bell Simpson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 230-20-5986	
17. INFORMANT Muriel Meehan		Address College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO (b) <i>acute myocardial failure</i> (c) <i>cerebral</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertensive arteriosclerosis, cardio vascular</i> (c) <i>renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/10, 19 67, to Aug 67, that (I) (we) last saw the deceased alive on Aug 14 19 67, and that death occurred at 7/10 M, from causes and on the date stated above.			
22a. SIGNATURE <i>W. C. Etienne</i>		22b. DATE SIGNED 8/14/67	
22c. PHYSICIAN'S NAME (Type) W. C. ETIENNE		22d. ADDRESS College Park, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Beaver Dan Church Cemetery		23d. LOCATION (City or Town) (County) (State) Fluvanna County Va.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE AUG 18 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

Centre Hospital
Lyon

Hypertension
Lyon

W.C. ETIENNE
Chirurgien
1/20
2/10
3/10
4/10
5/10
6/10
7/10
8/10
9/10
10/10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11370

11373

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Greenbelt // Hyattsville	
3. NAME OF DECEASED (Type or print) Annie		4. DATE OF DEATH Month 8 Day 1 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1892
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char woman	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 16 8377A	
17. INFORMANT Adeline Betts		Address Bellemead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5703 IMMEDIATE CAUSE (a) Infarction of sigmoid colon DUE TO Volvulus of sigmoid colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 8-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

3:21

3:21

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

John Jones, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11371

11374

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 27 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		d. STREET ADDRESS 4910 Newton St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gustav		4. DATE OF DEATH Month August Day 18 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/87
9. AGE (In years lost birthday) yrs. 80		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? British	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jerry Cesak		Address Bladensburg, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO Multiple Emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 1 , 19 67 , to Aug. 18 , 19 67 , that (I) (we) last saw the deceased alive on Aug. 18 , 19 67 , and that death occurred at 6:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Barry Rosenberg		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Barry Rosenberg		22d. ADDRESS 6501 Landover Road, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 8-19-67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland
24. FUNERAL DIRECTOR Nalley Funeral Home		25a. REC'D BY REGISTRAR AUG 22 1967	
ADDRESS Mt Rainier, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

avv. 45

George A. Henshaw

4630

2000年

1

8259A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11372

CERTIFICATE OF DEATH

11375

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk	
c. LENGTH OF STAY IN 1b 18 days		d. STREET ADDRESS % Post Office	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hazel M. Chaney		4. DATE OF DEATH Month August Day 1 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/12
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marion Phipps		14. MOTHER'S MAIDEN NAME Emma Rodgers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. 213-38-1237	
17. INFORMANT John Chaney, Dunkirk, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 445X IMMEDIATE CAUSE (a) Uremia DUE TO (b) Malignant Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/14 , 19 67 , to 8/11 , 19 67 , that (I) (we) lost saw the deceased alive on 8/11 , 19 67 , and that death occurred at 5:40 M, from causes and on the date stated above.			
22a. SIGNATURE W. Norman J. Comeau M.D.		22b. DATE SIGNED 8/11/67	
22c. PHYSICIAN'S NAME (Type) W. Norman J. Comeau		22d. ADDRESS 3503 Pennyst Mt Rainier Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Smithville Chr. Cemetery	23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md.
24. FUNERAL DIRECTOR Hutchins Funeral Home		25a. REG'D BY REGISTRAR Aug 4 1967 DATE	
ADDRESS Owings, Md.		25b. REGISTRAR'S SIGNATURE James J. Judge	

11378

OFFICE OF DEATH

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11378

11376

11373

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHERRY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT HEIGHTS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PR. Georges Gen L</u>		d. STREET ADDRESS <u>2400 ROCHELLE AVENUE</u>	
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>Anne</u> Last <u>CHAPMAN</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 22, 1965</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM C. CHAPMAN JR.</u>		14. MOTHER'S MAIDEN NAME <u>ANDREA C. HOOKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM C. CHAPMAN, SAME AS # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3403 Meningoencephalitis</u> DUE TO (b) <u>Unk. organism</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>8-6</u> , 19 <u>67</u> , that (I) <u>was</u> saw the deceased alive on <u>8-6</u> , 19 <u>67</u> , and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Peter Duus</u>		22b. DATE SIGNED <u>Aug. 6, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Peter Duus, M. D.</u>		22d. ADDRESS <u>6124 Central Ave. Capitol Hghts, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, PRINCE GEORGES, Md.</u>
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u> <u>4308 Suitland Road, Suitland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5491 • J. Neurosci., September 24, 2008 • 28(39):5485–5491

• *Journal of Management Education* 24(10):1139-1150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11374

11377

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b Approx 5 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood d. STREET ADDRESS 3709 Bunker Hill Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pearl E Chase		4. DATE OF DEATH Month Aug Day 1 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-87
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government - retired		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Steeman		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-4936	
17. INFORMANT Husband - 3709 Bunker Hill Rd - Brentwood, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transition DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized atherosclerosis DUE TO Peripheral occlusive vascular disease (c) 4500		INTERVAL BETWEEN ONSET AND DEATH 3 months years months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) and right leg amputation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1967 to 8-1, 1967 (not (I) (we) last saw the deceased alive on 7-30 1967 , and that death occurred at 12:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Jason Geiger		22b. DATE SIGNED 8-2-67	
22c. PHYSICIAN'S NAME (Type) Jason Geiger, M.D.		22d. ADDRESS 800 Pershing Dr.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/4/1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	23d. LOCATION (City or town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

REPORT OF DEATH

James G. Cooper

James G. Cooper

1871

1871

Chase

1871

1871

1871

1871

1871

1871

1871

James G. Cooper

James G. Cooper

James G. Cooper

James G. Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11375

11378

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b 06/29/67-8/16	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		d. STREET ADDRESS 7667 Walters Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens Health Care Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FILOMINA		4. DATE OF DEATH Month Aug Day 16 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/86
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months 1 Days 16 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Bernado		14. MOTHER'S MAIDEN NAME Patricia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219 56 0386	
17. INFORMANT Anthony Cherriro		18. ADDRESS 5019 Kerby Road Oxon Hill, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25, 1967 , to Aug 16, 1967 , that (I) (we) last saw the deceased alive on Aug 15, 1967 , and that death occurred at 1:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Harry G. Hadley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. G. HADLEY		22d. ADDRESS 4601 Nichols Ave SE Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-21-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City or Town) (County) (State) Wash, D.C.	
24. FUNERAL DIRECTOR Mallory 1311th St. S.E.D.C.		25a. REC'D BY REGISTRAR AUG 18 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones			

1943

UNITED STATES OF AMERICA

Department of the Interior

Bureau of Land Management

Washington, D.C.

Alaska

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11376		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11381	
1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainer	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3106 Taylor St.	
3. NAME OF DECEASED (Type or print) First Middle Last Anna M. Colgan				4. DATE OF DEATH Month Day Year August 3, 19 67	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/11/96		9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY C.&P.Tel.Co.		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, N.Y.	
13. FATHER'S NAME Edward Colgan		14. MOTHER'S MAIDEN NAME Nora Longworth		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Caroline A. Colgan - Sister-in-law Address #7 - Evelyn St Syossett, L.I., N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4201 DUE TO (b) Coronary Vascular Disease DUE TO (c) Hypertensive Ht Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 6 HRS 5 YRS 5 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <u>Aug. 3, 1967</u> , to <u>Aug. 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 3, 1967</u> , and that death occurred at <u>3:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Miller		22b. ADDRESS 3824-34th St. Mt. Rainer, Maryland		22c. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M. D.		22d. ADDRESS 3824-34th St. Mt. Rainer, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Com.	
23d. LOCATION (City or Town) (County) (State) Wash. D.C.		24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. ADDRESS Mt. Rainer Maryland			
25a. REC'D BY REGISTRAR DATE AUG 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



Overseas

5 Nov. 50 when Mr. Baker

Prince Georges Hospital

4310 Taylor St.

Anna

Colman

Amber

Marie

Marie

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

11377

CERTIFICATE OF DEATH

11382

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 11 hr. 29mins d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 7612 Fountainbleau Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby First Middle Last Collins		4. DATE OF DEATH Month Day Year August 29, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1967
9. AGE (In years lost birthday) yrs. 11 Months 29 Days 11 Hours 29 Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cheverly, P.G. Co.	
11. BIRTHPLACE (County & State, or foreign country) Cheverly, P.G. Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Franklin Collins		14. MOTHER'S MAIDEN NAME Susan Katherine Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prematurity DUE TO (b) Atelectasis of lungs, bilateral. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from Aug. 28, 1967 to Aug. 29, 1967 , that (I) was lost saw the deceased alive on Aug. 29, 1967 , and that death occurred at 5:11AM , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.		22d. ADDRESS 6201 Riverdale Rd. Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 9/2/67	23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly PG Maryland	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Harry W. Perry, Jr., Admin., Cheverly, Md.		25a. REC'D BY REGISTRAR SEP 6 1967	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11378

CERTIFICATE OF DEATH

11383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE LABRADOR, CANADA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 34	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS QUARTERS 540B	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle SCOTT Last CUNNINGHAM		4. DATE OF DEATH Month AUGUST Day 19 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 14, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Applicable		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM F., JR.		14. MOTHER'S MAIDEN NAME JOSEPHINE MERRITT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT PATIENT RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overwhelmed by Sepsis 053.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Epidemiologic Bull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 38d	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/16/67 to 8/19/67 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at 19 M, from causes and on the date stated above.			
22a. SIGNATURE Cap t. Roger E. Spitzer		22b. DATE SIGNED 8/19/67	
22c. PHYSICIAN'S NAME (Type) Cap t. Roger E. Spitzer		22d. ADDRESS 3302 Curtis Drive Hillcrest Heights, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Bur.	23b. DATE THEREOF 8/25/1967	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Columbus, Ohio
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR DATE AUG 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

00012

STATE OF NEW YORK

1911

IN SENATE

JANUARY 11, 1911

REPORT

OF

THE COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1910

ALBANY: J.B. LEECH, STATE PRINTER, 1911.

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15807

1. PLACE OF DEATH a. COUNTRY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 74 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights d. STREET ADDRESS 2725 Bellbrook Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Christine Marie Cupp		4. DATE OF DEATH Month Day Year August 7 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-67
9. AGE (In years lost birthday) yrs. 4		10. BIRTHPLACE (State or foreign country) Washington, D. C.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Cupp		14. MOTHER'S MAIDEN NAME Dorothy M. Naer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George H. Cupp, Same as Item #2 (Father)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7545 IMMEDIATE CAUSE (a) Congenital Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 8-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/10/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR W. W. Chambers Co., 517 11th St., S.E., Wash. D.C.		25a. REC'D BY REGISTRAR NOV 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12881

WEDNESDAY, JANUARY 10, 1961

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

12881

VR A15 (4)
25M 1/67

VR A15 (4)
25M 1/67

Presigned John Harvey Ken Medical Center

11384

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 55 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 7631 Goodland Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles W. Denson		4. DATE OF DEATH Month Aug. Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/57
9. AGE (In years last birthday) yrs. 10 9		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (County & State, or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Denson	
14. MOTHER'S MAIDEN NAME Janice Seymour		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO (b) cerebral palsy DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Aug. 24, 1967 , to Aug. 24, 1967 , that (X) (we) last saw the deceased alive on Aug. 24, 1967 , and that death occurred at 3:25 PM , from causes and on the date stated above			
22a. SIGNATURE Harold Y. Finck, M. D.		22b. DATE SIGNED AUG 28 1967	
22c. PHYSICIAN'S NAME (Type) Harold Y. Finck, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL CREMATION, REMOVAL, SPECIFY	23b. DATE THEREOF 28 AUG 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington	23d. LOCATION (City or Town) (County) (State) Arlington Va
24. FUNERAL DIRECTOR 1400 Georgia Ave NW		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 28 1967	

respiratory failure
cardiac failure

of only 1/2

Prince George General Hospital

George V. Road, N. B.

AUG 2 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11 & 12 Film #G493 10/3/67 ph

CERTIFICATE OF DEATH

11380

12829

1. PLACE OF DEATH o. COUNTY Pr. George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9708 47th Place				d. STREET ADDRESS 9708 47th Place			
3. NAME OF DECEASED (Type or print) First Middle Last Dora Ellen DICKERSON				4. DATE OF DEATH Month Day Year August 27 19 67			
b. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 February '77		9. AGE (In years last birthday) 90		IF UNDER 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bolt				14. MOTHER'S MAIDEN NAME Martha Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Son		Address 4719 Edgewood Rd. Coll. Pk.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH immediate unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 July 1966 , to present , 19 67 , that (I) (we) last saw the deceased alive on 11 August 19 67 , and that death occurred at 7 P.M. from causes and on the date stated above.							
22a. SIGNATURE Carl J. Houmann				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 27 Aug. 1967	
22c. PHYSICIAN'S NAME (Type) Carl J. Houmann				22d. ADDRESS Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/28/67		23c. NAME OF CEMETERY OR CREMATORY East End Cem.		23d. LOCATION (City or town) (County) (State) Waltham, Waltham Co	
24. FUNERAL DIRECTOR John F. Wierman				25a. REC'D BY REGISTRAR SEP 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11385

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3509 Rhode Island Avenue		d. STREET ADDRESS 3509 Rhode Island Ave.	
3. NAME OF DECEASED (Type or print) Elizabeth Eleanor Dodson		4. DATE OF DEATH Month 8 Day 31 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-18
9. AGE (In years) 49 yrs.		IF UNDER 1 YEAR Months 11 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT ROBERT G. DODSON		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot self in head	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:30pm p.m. 8-31 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Mt. Rainier, P.G., Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 9-1-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT 5, 1967	23c. NAME OF CEMETERY OR CREMATORY FOREST LAWN CEM	23d. LOCATION (City or Town) (County) (State) POMPAUN BEACH, FLORIDA
24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.		25a. REC'D BY REGISTRAR DATE SEP 8 1967	25b. REGISTRAR'S SIGNATURE [Signature]

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332

1-332



1-332

1-332

1-332



1-332

1-332

1-332

1-332

FOR STATE
HEALTH DEPT.

11382

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 3121 75th. Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Monroe Middle H Last Edwards				4. DATE OF DEATH Month 8 Day 8 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 June 1896		9. AGE (In years last birthday) yrs. 71	10. IF UNDER 1 YEAR Months 8 Days 8 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 245189115A		17. INFORMANT ROBERT M. EDWARDS Address 12821 HOLDRIDGE RD SILVER SPRING, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		22. DATE SIGNED 8-9-67		22. DATE SIGNED 8-9-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR W. L. CHAMBERS Co.		ADDRESS Riverdale, Md.		25a. READ BY REGISTRAR AUG 14 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11383		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11387	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Sarasota		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sarasota	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital			d. STREET ADDRESS 1810 Grove Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Oscar First Mencure Middle Embrey Last			4. DATE OF DEATH Month August Day 11 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 April 1887		9. AGE (In years last birthday) yrs. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Heating Cent.		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Charles Embrey			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME Colbert		
16. SOCIAL SECURITY NO. 579-32-8826		17. INFORMANT Address David Embrey 4016 Madison St., Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) yes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 19 67 to 8-11 , 19 67 , that (I) (we) last saw the deceased alive on 7-30 , 19 67 , and that death occurred at 6:50 PM , from causes and on the date stated above.					
22a. SIGNATURE Donald C. Edgren		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-12-67	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS 3500 East West Highway, Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/15/67	23c. NAME OF CEMETERY OR CREMATORY Manasota Cemetery	23d. LOCATION (City or Town)	(County)	(State) Manatee County, Florida
24. FUNERAL DIRECTOR GASCH'S			ADDRESS HYATTSVILLE, MARYLAND		25a. REC'D BY REGISTRAR AUG 15 1967
			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Washington					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Washington				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 13115--Fort Washington Rd., S. E.					d. STREET ADDRESS 13115--Fort Washington Rd., SE				
3. NAME OF DECEASED (Type or print) First JOSEPH Middle C. Last ENNIS, Jr.					4. DATE OF DEATH Month August Day 14th Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4th, 1901		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. Ennis, Sr.					14. MOTHER'S MAIDEN NAME Mamie Murphy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 578-16-0396		17. INFORMANT Mrs. Hazel M. Ennis, (Wife)		Address Same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 Hepatic cirrhosis, nutritional. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None								INTERVAL BETWEEN ONSET AND DEATH Over 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 Aug 14, 1967				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1967 to Aug 14, 1967 , that (I) (we) last saw the deceased alive on Aug 10, 1967 , and that death occurred at 6:50 M, from the causes and on the date stated above.									
22a. SIGNATURE James R. Snyder					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug. 14th-1967		
22c. PHYSICIAN'S NAME (Type) Dr. James R. Snyder					22d. ADDRESS 916-19th St., N. W., Wash. DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug. 16th, 67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.					ADDRESS 1661-Good Hope Rd., SE Wash DC		25a. REC'D BY REGISTRAR AUG 15 1967		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

494

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>30 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 Morris Drive, Apt 20</u>		d. STREET ADDRESS <u>Laurel Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Deland Mem. Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Michael Falzoi</u>		4. DATE OF DEATH <u>8-21-67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) yrs. <u>1</u> Month <u>1</u> Day <u>7</u> 19 <u>67</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Pr. Geo. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Falzoi Robert E</u>		14. MOTHER'S MAIDEN NAME <u>Keyes, Jennifer</u>	
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-20</u> , 19 <u>67</u> , to <u>8-21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-20</u> , 19 <u>67</u> , and that death occurred on <u>8:05</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D. R. Purdie</u>		22b. DATE SIGNED <u>8-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald R. Purdie, M.D.</u>		22d. ADDRESS <u>4400 Queensbury Rd. Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel PG Md.</u>
24. FUNERAL DIRECTOR <u>Donald R. Purdie</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Laurel Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 23 1967</u>			

7-277333

882-1

RECEIVED 1762-1103

RECEIVED

JUN

11386

CERTIFICATE OF DEATH

11390

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. LENGTH OF STAY IN 1b <u>7 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47.3</u>
3. NAME OF DECEASED (Type or print) <u>John Fitzpatrick</u>		d. STREET ADDRESS <u>4112-12th St N.E.</u>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Community Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fitzpatrick</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAJ</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	11. BIRTH PLACE (County & State, or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>John Fitzpatrick</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Langley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578 66 8848T</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Chronic Ischemic Heart Disease</u> DUE TO (c) <u>Coronary Artery Sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericardial Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1958</u> to <u>8/26/1967</u> , that (I) (we) last saw the deceased alive on <u>7/14/1967</u> , and that death occurred <u>8:30 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edmund Lyddane</u>		22b. DATE SIGNED <u>8/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E Stuart Lyddane</u>		22d. ADDRESS <u>3066 Q Street N.W. Wash., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Nalley Funeral Home</u>		25a. REC'D BY REGISTRAR <u>AUG 30 1967</u>	
ADDRESS <u>Mt Rainier, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MAKING STATE DEPARTMENT OF HEALTH
AND MENTAL HYGIENE
DIVISION OF MENTAL HYGIENE
WASHINGTON, D. C.

George Washington University
Department of Psychiatry
Washington, D. C.

7/7/47
7/7/47
7/7/47
7/7/47

George Washington University

7/7/47

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card-box papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11387		11391	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home		d. STREET ADDRESS 2000 Van Buren Street	
3. NAME OF DECEASED (Type or print) Thomas C. Gardner Sr.		4. DATE OF DEATH Month August Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE Caucasion	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1897
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR: Months 17 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Bur. of Engr.	
11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Gardner		14. MOTHER'S MAIDEN NAME Ellen Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO Yes WWI		16. SOCIAL SECURITY NO. 220-44-5439	
17. INFORMANT Patricia A. Gardner		Address 2000 Van Buren St. Wash.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X Adenocarcinoma of the Lung IMMEDIATE CAUSE (a) Adenocarcinoma of the Lung DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 19 67 to 17 Aug , 19 67 , that (I) (we) lost saw the deceased alive on 17 Aug 19 67 , and that death occurred at 4:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Wm. A. Wimsatt		22b. DATE SIGNED 17 Aug. 1967	
22c. PHYSICIAN'S NAME (Type) Wm. A. Wimsatt M.D.		22d. ADDRESS 3415 Hamilton St, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/21/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com.	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE AUG 22 1967	
ADDRESS Mt. Rainier Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

the occurrence of the thing

Stenanthus carolinensis

Wm A. Wimsitt, A.M. Wimsitt, W.B. Wimsitt

11386

CERTIFICATE OF DEATH

11392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PR. George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON MD.</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAYO MD.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern MD. Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HAZEL</u> First <u>Harriet</u> Middle <u>Harriet</u> Last <u>Gatts</u>		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/24/1907</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WVA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>HARRY Richmond</u>		14. MOTHER'S MAIDEN NAME <u>CLARA Yoko</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>719-16-3969</u>	
17. INFORMANT <u>Robert Gatts (husb)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cyberrespiratory Collapse</u> DUE TO (b) <u>Oncenomatous general</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>3-5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerotic heart disease & myocardium</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-14</u> , 19 <u>67</u> , to <u>8-16</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8-16</u> , 19 <u>67</u> , and that death occurred at <u>2:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapen</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPEN MD</u>		22b. DATE SIGNED <u>8-16-67</u>	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, MD</u>
24. FUNERAL DIRECTOR <u>TA Hardesty</u>		ADDRESS <u>12 Ridgely Ave Annapolis, Md</u>	
25a. REC'D BY REGISTRAR <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

Albany, N. Y.
August 1, 1918

Albany, N. Y.
August 1, 1918

8-14 8-15 8-16 8-17 8-18 8-19 8-20 8-21 8-22 8-23 8-24 8-25 8-26 8-27 8-28 8-29 8-30 8-31

Office of the Registrar
Albany, N. Y.

Albany, N. Y.
August 1, 1918

Albany, N. Y.
August 1, 1918

CERTIFICATE OF DEATH

11389

11393

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>	
c. LENGTH OF STAY IN 1b <u>5 YEARS</u>		d. STREET ADDRESS <u>6015 OLD BRANCH AVENUE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Md. General Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles E Glotfelty</u>		4. DATE OF DEATH <u>8 25 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-07</u>
9. AGE (In years last birthday) <u>59 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thaddeus Glotfelty</u>		14. MOTHER'S MAIDEN NAME <u>Welch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>176-03-3031</u>	
17. INFORMANT <u>George Glotfelty Same as # 2</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Congestive Heart Failure</u> DUE TO (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>20-30 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u></u> at work <u></u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>8-12</u> , 19 <u>67</u> , to <u>8-17</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-17</u> , 19 <u>67</u> , and that death occurred at <u>2 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>David N. Robb</u>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>David N. Robb, M. D.</u>		22d. ADDRESS <u>5116 Middleton Lane, Camp Springs, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Nebo Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Saltlick, Fayette, Penna.</u>
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
4308 Suitland Road, Suitland, Maryland		DATE <u>AUG 28 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

WILLIAM B. GILBERT, Esq., Solicitor-General,
4001 Broadway, New York, N.Y.
WILLIAM B. GILBERT, Esq., Solicitor-General,
4001 Broadway, New York, N.Y.
WILLIAM B. GILBERT, Esq., Solicitor-General,
4001 Broadway, New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please renew carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11380

CERTIFICATE OF DEATH

11384

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5832 2nd AVENUE		d. STREET ADDRESS 5832 2nd AVENUE	
3. NAME OF DECEASED (Type or print) JOSEPH CLAYTON GORDON		4. DATE OF DEATH Month AUGUST Day 9 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 25, 1908
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED U S PARK POLICE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME VERNON GORDON		14. MOTHER'S MAIDEN NAME ANNIE FERGUSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT SARA ELIZABETH GORDON		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Intestine. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 months 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 63 , to August , 19 67 , that (I) (we) last saw the deceased alive on August 19 67 , and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert F. Dyer		22b. DATE SIGNED 8-9-67	
22c. PHYSICIAN'S NAME (Type) ROBERT F. DYER		22d. ADDRESS 915 19th STREET N.W. WASHINGTON D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/11/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) SUITLAND PRINCE GEORGES, Md.
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME		25a. REC'D BY REGISTRAR DATE AUG 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1-13-4

DEPT. OF STATE

1-13-4

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

[Faint, illegible handwritten text]

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11395									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seabrook c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seabrook d. STREET ADDRESS 9616 Van Buren Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James C. Gose			4. DATE OF DEATH Month August Day 25 Year 1967						
5. SEX Male		6. CDOLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/84		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME James B. Gose					14. MOTHER'S MAIDEN NAME Frances Shoemaker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SDICIAL SECURITY NO. (If yes give war or dates of service)		17. INFDRMANT Jeanne Draughn Address Seabrook, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) generalized debility anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diffuse pelvic Hodgkin's (c) adenocarcinoma of prostate								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 60								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 64 , 19 64 , to 25 Aug, 67 , that (I) (we) last saw the deceased alive on 24 Aug 1967 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE James W. Harding, M.D.					22b. DATE SIGNED Aug. 25, 1967				
22c. PHYSICIAN'S NAME (Type) James W. Harding, M.D.					22d. ADDRESS 7601 Riverdale Rd. Lanham, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Temple Hill Cemetery		23d. LOCATION (City, town or county) (State) Castle Wood Virginia			
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE AUG 28 1967		25b. REGISTRAR'S SIGNATURE Charles J. ...		

1000

Prince George

Mayland

Prince George

Geobrook

2 days

Chavaly

9810 Van Hornen Street

Prince George General Hospital

August 25, 1967

Good

1 year

83

8/3/84

xx

White

also

0.2

17.2

17.2

17.2

Prince George General Hospital

Prince George General Hospital

Prince George General Hospital

no

Aug. 25, 1967

7501 Riverdale Rd. Tampa, Maryland

James W. Harding, M.D.

Prince George General Hospital

Prince George General Hospital

Aug. 25, 1967

Aug. 25, 1967

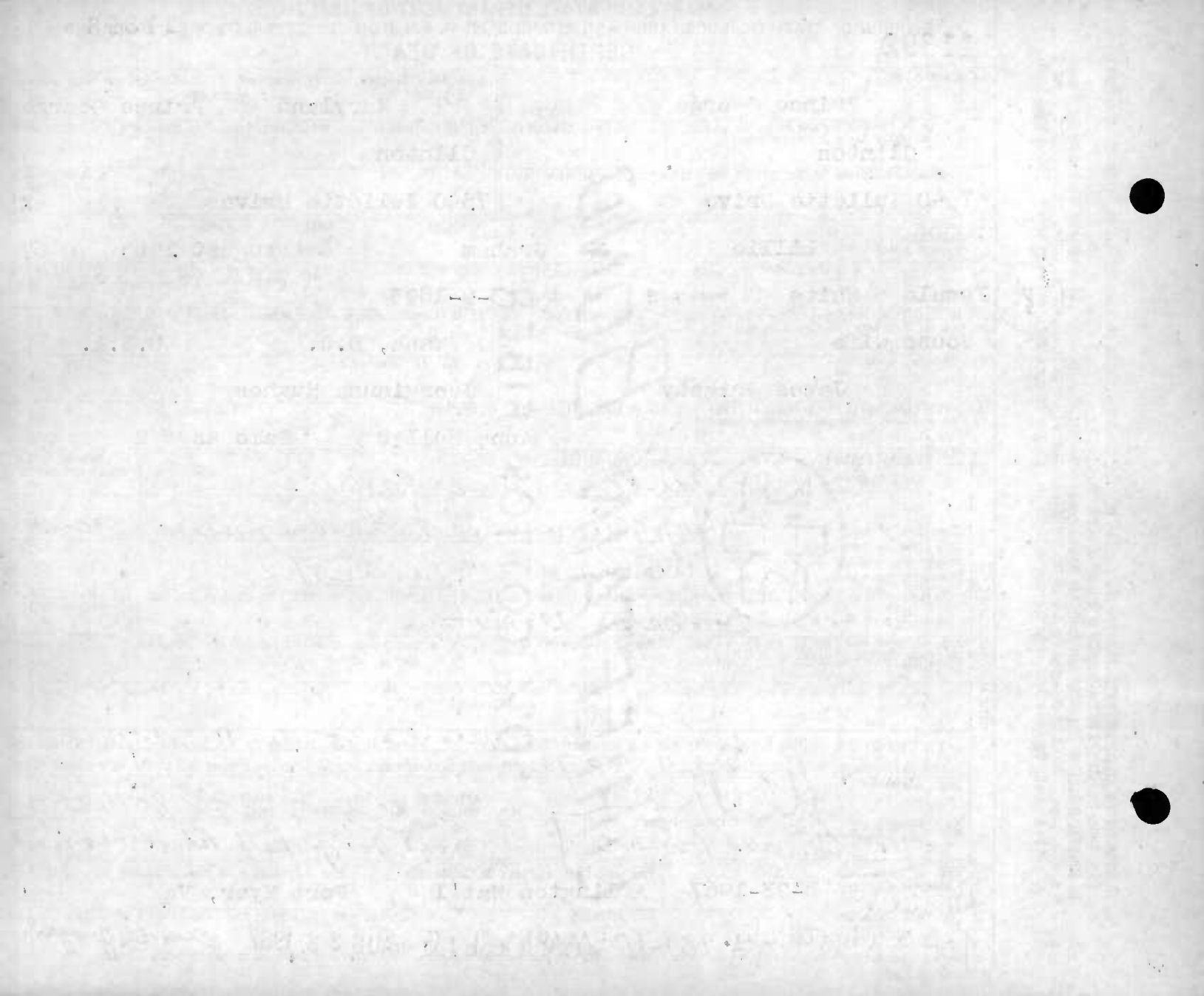
Aug. 25, 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
11392 CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton 16-1																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7540 Juliette Drive						d. STREET ADDRESS 7540 Juliette Drive																	
3. NAME OF DECEASED (Type or print) First Middle Last Lillie M Graham						4. DATE OF DEATH Month Day Year August 19th 19 67																	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-1893		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wash, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.													
13. FATHER'S NAME James Grigsby						14. MOTHER'S MAIDEN NAME Georgianna Hughes																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Anna Muller				Address Same as # 2													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute cardiac failure DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) Generalized arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Diabetes Mellitus										INTERVAL BETWEEN ONSET AND DEATH several													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from March 1965, to Aug 11, 1967, that (I) (we) last saw the deceased alive on Aug 11, 1967 and that death occurred at M, from the causes and on the date stated above.																							
22a. SIGNATURE Dr David Anders						22b. DATE SIGNED 8-19-67																	
22c. PHYSICIAN'S NAME (TYPE) Dr David Anders						22d. ADDRESS 2308 Dodge Park Rd Alexandria, Va																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-23-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l				23d. LOCATION (City, town or county) (State) Fort Myer, Va													
24. FUNERAL DIRECTOR Robert A Mattingly						25a. REC'D BY REGISTRAR 131-17th St NW Wash DC						25b. REGISTRAR'S SIGNATURE Charles Judge											
DATE AUG 22 1967																							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11393

11397

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,		c. LENGTH OF STAY IN 1b 23 days 8hr. 20 min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 7001 Riggs Road	
3. NAME OF DECEASED (Type or print) Mary First E. Middle Grant Last		4. DATE OF DEATH Month 8 Day 2 Year 1967	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/18/05
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months 2 Days 16 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Bird		14. MOTHER'S MAIDEN NAME Jennie West	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x POSS CORONARY OCCLUSION DUE TO (b) Diabetic Arteriosclerosis H.D. DUE TO (c) stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 15 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Large intra abd. abscess			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to August 1967 that (I) (we) last saw the deceased alive on Aug 1 1967, and that death occurred at 66 M, from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/5/67	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR <i>[Signature]</i>		25. REC'D BY REGISTRAR AUG 7 1967	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

100-1

U.S. DEPT. OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

WASHINGTON, D.C.

U.S. DEPT. OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

11394

11398

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital				d. STREET ADDRESS 4604 Amherst Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Kitson Grau				4. DATE OF DEATH Month 8 Day 5 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-26-1944		9. AGE (In years lost birthday) yrs. 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Playground		10b. KIND OF BUSINESS OR INDUSTRY Asst Director		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fred V Grau				14. MOTHER'S MAIDEN NAME Anne Fagan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 42 7305		17. INFORMANT Fred V. Grau		Address College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9250 IMMEDIATE CAUSE (a) Asphyxiation DUE TO Exhaustion of oxygen in closed refrigerator Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in closed refrigerator					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 8-5- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Basement of home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. M.D.				22. DATE SIGNED 8-6-67			
EXAMINER'S NAME (Type) John Kehoe, M.D.				Address (Street, city, town, or county) Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Center County Memorial Park		23d. LOCATION (City or Town) (County) (State) State College Center Pa	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 7 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

11.3.18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11395

CERTIFICATE OF DEATH

11399

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE		c. LENGTH OF STAY IN 1b 2 MONTHS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.		d. STREET ADDRESS 1213 CARRLEBURG PLACE S.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GLENN DALE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT GRIMES SR.		4. DATE OF DEATH Month 8 Day 19 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/18
9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR Months 4 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME GEORGE GRIMES		14. MOTHER'S MAIDEN NAME ANNA MAE WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NAVY 1951-3		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT DECEASED		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X RECURRENT CEREBRAL THROMBOSIS DUE TO (b) GENERALIZED ARTERIOCLEROSIS DUE TO (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) OLD MYOCARDIAL INFARCTION, CHRONIC URINARY TRACT INFECTION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/23 , 19 67 , to 8/19 , 19 67 , that (I) (we) last saw the deceased alive on 8/18 , 19 67 , and that death occurred 12:54 M, from causes and on the date stated above.			
22a. SIGNATURE Wm Wm		22b. DATE SIGNED 8/19/67	
22c. PHYSICIAN'S NAME (Type) GLENN DALE HOSP, GLENN DALE, MD.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-25/67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park Landover Md.	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR Johnson & Jenkins 4804 Ba. Ave. N.W.		25a. REC'D BY REGISTRAR DATE AUG 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1938

OFFICE OF THE

1938



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11396

CERTIFICATE OF DEATH

11400

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights	
c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6019 1st Street	
3. NAME OF DECEASED (Type or print) First Middle Last Luther W Gunner		4. DATE OF DEATH Month Day Year Aug. 24 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894
9. AGE (In years last birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Gov't		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Octavia Hargrove, Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Azotemia, severe DUE TO (b) Etiology pending Histologic examination Pulmonary Edema DUE TO (c) Old Infarct, left internal capsule		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the this hospital) attended the deceased from July 26, 1967 , to Aug. 24, 1967 , that he (we) last saw the deceased alive on Aug. 24, 1967 , and that death occurred at 5:15 AM from causes and on the date stated above.			
22a. SIGNATURE R.B. Ingham		22b. DATE SIGNED Aug. 24, 1967	
22c. PHYSICIAN'S NAME (Type) Roger B. Ingham, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, or other (Specify) Burial	23b. DATE THEREOF Aug. 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Coleman	23d. LOCATION (City or Town) (County) (State) Fairfax Co. Va.
24. FUNERAL DIRECTOR Greene Funeral Home, Alexandria, Va.		25a. REC'D BY REGISTRAR AUG 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

74

3

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11397									
CERTIFICATE OF DEATH									
11401									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
c. LENGTH OF STAY IN 1b 4 hrs.25 mins					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 1415-58th Ave.				
3. NAME OF DECEASED (Type or print) Leornard Harrison					4. DATE OF DEATH Month August Day 28 Year 19 67				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 1899		9. AGE (In years last birthday) yrs. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck farmer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (County & State, or foreign country) Mecklenburg Co. N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Kistler Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Girlever Ginyard		Address 5710 Oates St, N.E.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Aortic Aneurysm. DUE TO (b) Arteriosclerotic Cardiovascular Disease. DUE TO (c) 									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 28, 1967 , to Aug. 28, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 28, 1967 , and that death occurred at 1:55 AM from causes and on the date stated above.									
22a. SIGNATURE Hernandez m				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Tomas Hernandez, M. D.				22d. ADDRESS Prince Georges General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-67		23c. NAME OF CEMETERY OR CREMATORY Harmony MEMORIAL Park			23d. LOCATION (City or Town) (County) (State) 7601 Sheriff Rd, N.E. Md		
24. FUNERAL DIRECTOR J. H. Taylor				ADDRESS 909 6th St, N.W.		25a. REC'D BY REGISTRAR DATE SEP 1 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

11401

STATE OF TEXAS

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

1800

1800

1800

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

1800

1800

1800

1800

1800

1800

Prince George

Prince George

Prince George

Prince George

1800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11398		11402	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
c. LENGTH OF STAY IN 1b 1 yr.		d. STREET ADDRESS 3818 Blaine St., N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary E. Hawkins		4. DATE OF DEATH Month 8 Day 3 Year 19 67	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/1892
9. AGE (In years lost birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Lee		14. MOTHER'S MAIDEN NAME Mary A. Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. 579-10-8315	
17. INFORMANT decendent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus; hypertensive and arteriosclerotic heart disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/5/66 , 19 67 , to 8/3/19 67 , that XX (we) last saw the deceased alive on 8/3/19 67 , and that death occurred at 11:15 PM from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 8/3/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8/8/1967	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR Pope Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

REPORT OF CASE

Prince George

Washington, D. C.

1 yr.

Glenn Dale (Royal)

2815 Blake St., N.W.

Glenn Dale Hospital

June 8/31

Hawkins

H.

Harry

12

2/21/1932

X

H

F

024

Washington, D. C.

unknown

Hawkins

Harry A. Inge

Charles H. Lee

unknown

279-10-812

none

1-1-52

Glenn Dale Hospital

unknown

Glenn Dale Hospital

unknown

Glenn Dale Hospital

Glenn Dale Hospital

8/31/31

8/31/31

8/31/31

8/31/31

X

Glenn Dale Hospital, Glenn Dale, Md.

Hos. No. 1, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11399		11403	
1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		b. COUNTY Prince George	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 9909 Baltimore Ave.	
3. NAME OF DECEASED (Type or print) CLARA L. HEAL		4. DATE OF DEATH Month Day Year Aug 16 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-84
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leypoldt, Christopher		14. MOTHER'S MAIDEN NAME FANNIE GATES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) X NO		16. SOCIAL SECURITY NO. 220-44-9609	
17. INFORMANT Neice and Medical Records, June Leypoldt		18. ADDRESS 4780 Edgewood Rd. College Park, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Chronic Nephritis & Uremia (b) Advanced Cerebral Arteriosclerosis DUE TO Arterio-sclerotic Cardio-vascular system disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966, 19 to Aug 15, 1967, and that death occurred at 11 AM, from causes and on the date stated above.			
22a. SIGNATURE W. J. Etienne		22b. DATE SIGNED 8/16/67	
22c. PHYSICIAN'S NAME (Type) W. J. ETIENNE		22d. ADDRESS College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS, EPISCOPAL (EM)		23d. LOCATION (City or Town) (County) (State) BELTSVILLE, MARYLAND	
24. FUNERAL DIRECTOR W W Chambers Co Riverdale Md.		25a. REC'D BY REGISTRAR DATE AUG 21 1967	
25b. REGISTRAR'S SIGNATURE John G. Judge			

11408

CERTIFICATE OF DEATH

1907

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF OTHER PERSON

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF PHYSICIAN

NAME OF OTHER PERSON

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF OTHER PERSON

DATE OF SIGNATURE

PLACE OF SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11400

11404

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rt. #2, Box 227 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louise A. Hill		4. DATE OF DEATH Month Day Year August 3, 1967	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/04
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min. 16-1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matron		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Gray		14. MOTHER'S MAIDEN NAME Edith Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Catherine E. Hill - Brandywine, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, terminal DUE TO (b) Carcinoma of the Uterus DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from July 24, 1967 , to Aug. 3, 1967 , that he (we) last saw the deceased alive on Aug. 3, 1967 , and that death occurred at 10:45M , from causes and on the date stated above.			
22a. SIGNATURE <i>William B. Gunther</i> M.D.		22b. DATE SIGNED 8/4/67	
22c. PHYSICIAN'S NAME (Type) William B. Gunther, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF Aug-8-1967	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City or town) (County) (State) Clinton, Maryland Pr. Geo. C.
24. FUNERAL DIRECTOR <i>Prince Funeral Home</i>		25a. REC'D BY REGISTRAR DATE AUG 9 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11822

CHIEF OF DEPT.

11822

George George

George

George George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11401

11405

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. State County: PRINCE GEORGES b. County State: MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS d. STREET ADDRESS 5710 Davis Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH CHARLES HIGGINS		4. DATE OF DEATH AUGUST 24 1967	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 February 1918 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED MILITARY	9. AGE (In years last birthday) 49 yrs.
11. BIRTHPLACE (County & State, or foreign country) NEW YORK, NY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD LAWRENCE HIGGINS		14. MOTHER'S MAIDEN NAME ADELINE LOUISE VOSBURGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES		16. SOCIAL SECURITY NO. 17. INFORMANT 672 E 234 St Bronx, NY 10466 Brother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DIABETIC KETOACIDOSIS (c) DIABETES MELLITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 24 August 1967 to 24 August 1967 that (X) (we) last saw the deceased alive on 24 August 1967, and that death occurred at 8:30 AM from the causes and on the date stated above.			
22a. SIGNATURE John F. Lindeman M.D.		22b. DATE SIGNED 24 Aug 67	
22c. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT USAF		22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL CREMATION (Specify) Burial		23b. DATE THEREOF 8/28/67	
23c. NAME OF CEMETERY OR CREMATORY LONG ISLAND NATIONAL		23d. LOCATION (City, town or county) (State) NEW YORK	
24. FUNERAL DIRECTOR'S SIGNATURE Jas. Hawley Sons Inc		25a. REC'D BY REGISTRAR SEP 1 1967	
ADDRESS 5130 Wise Ave N.W. Wash. D.C.		25b. REGISTRAR'S SIGNATURE J Charles Judge	

1100

NEW YORK

NEW YORK

NEW YORK

CAMP SPRING

CAMP SPRING

210 Davis Boulevard

210 Davis Boulevard

JOSEPH CHARLES HIGGINS

175 5th Avenue

NEW YORK

NEW YORK

NEW YORK

AGNES LOUISE VORBERG

AGNES LOUISE VORBERG

835 E. 1st St.

Brooklyn, NY

SHOCK

TRANSIT RECORDS

TRANSIT RECORDS

20 August 57

8:30

19 August 57

USAT Hospital Andrews

JOHN T. LINDENMAN, CAPT USARMC

Andrews AFB, Wash DC 20332

JOHN T. LINDENMAN, CAPT USARMC

SEP 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME
6M 1/67

11402

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11406

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virgin ia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Base Hospital		d. STREET ADDRESS 9116 Leesburg Pike	
3. NAME OF DECEASED (Type or print) Eric Windsor Hitchcock		4. DATE OF DEATH 8 Month 12 Day 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years birth day) 20 Jan., 1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dal Hitchcock		14. MOTHER'S MAIDEN NAME Mildred Houmiller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Dal Hitchcock - Father		Address #2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8164 Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Trauma-Auto accident (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in collision.	
20c. TIME OF INJURY Month, Day, Year 11:00 pm 8-12-67		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Cedarville Rd., Brandywine, P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 8-13-67	
ACTUAL SIGNATURE John Kehoe, M.D., Prince George Co		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8-13-67	
23c. NAME OF CEMETERY OR CREMATORY Georgetown Med. School		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Robert A. DeSol		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

1100

Item #7 Film #G392 9/8/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11403

11407

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4000 Brook Drive, Apt. 616		d. STREET ADDRESS 4000 Brook Drive, Apt. 616	
3. NAME OF DECEASED (Type or print) Lillian Irene Hoffman		4. DATE OF DEATH Month 8 Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-1918
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months 4 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Survey Statistian		10b. KIND OF BUSINESS OR INDUSTRY Census Bureau	11. BIRTHPLACE (State or foreign country) Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James L Hoffman	
14. MOTHER'S MAIDEN NAME Miriam C Berkstresser		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 578-10-4728		17. INFORMANT James L Hoffman Address University Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of aneurysm of left anterior cerebral artery 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 8-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 4, 1967	23c. NAME OF CEMETERY OR OTHER PLACE OF INTERMENT Salem Union	23d. LOCATION (City or Town) (County) (State) Dover Pa.
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

100-1

James C. ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

CERTIFICATE OF DEATH

11404

11408

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Lanham</u> c. LENGTH OF STAY IN 1b <u>7 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Residence</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>P. G</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> d. STREET ADDRESS <u>9103 Wallace Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie</u> <u>Holloway</u> <u>Aug</u>				4. DATE OF DEATH Month Day Year <u>Aug</u> <u>27</u> <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Virginia</u> <u>77</u> yrs.	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Amherst, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Preston Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Edna Gatewood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT Address <u>Lanham, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>D Thyroid Tumor (substernal); Leukemia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/26/67</u> to <u>8/27/67</u> ; that (I) (we) last saw the deceased alive on <u>8/26/67</u> , and that death occurred on <u>8/27/67</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry A. Wise Jr.</u> M.D.				22b. DATE SIGNED <u>8/27/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u>				22d. ADDRESS <u>9105 Volta St, Lanham, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		23d. LOCATION (City, town or county) (State) <u>Subsident Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lucius Funeral Home Wash DC</u>				25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1808

WESTERN OF DEATH

P.C.

Good

Good

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

James (Lambert)

James

James

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office on with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

7-245-99

FOR STATE
HEALTH DEPT.

M

99

MEDICAL CERTIFICATION

11405				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11409			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
Prince George's		Cheverly		DOA		Hyattsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS							
Prince George General Hospital				4242 Forest Road							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH							
Richard Allen Hood				8 3 19 67							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		17 July 1967		17 17 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
None								Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Allen Baxter Hood				Barbara Jean Harris				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
								Allen Baxter Hood Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.)								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pneumonitis											
763.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) SDII											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				8-4-67			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				8/5/1967		Sedar Hill		Switzland, Prince George's			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert A. Mattingly				131-11-1418		AUG 8 1967		Charles Judge			

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

11008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE OHIO b. COUNTY MAHONING						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) YOUNGSTOWN						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS					d. STREET ADDRESS 916 PARKWOOD AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH E HOWARD					4. DATE OF DEATH Month Day Year Aug. 6 1967						
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 AUG 36		9. AGE (In years last birthday) yrs. 31			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN			10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (County & State, or foreign country) CAMPBELL, OHIO			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM MOSES HOWARD					14. MOTHER'S MAIDEN NAME GEORGIA LEE WARDS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES			16. SOCIAL SECURITY NO. 300-30-7344		17. INFORMANT WIFE			Address SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest followed by Cardiac Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Episodes of severe Bronchospasm</u> DUE TO (c) <u>Allergic and Probably infectious Bronchial Asthma</u>										INTERVAL BETWEEN ONSET AND DEATH Approx 1hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from <u>7 Jul</u> , 19 <u>67</u> , to <u>6 Aug</u> , 19 <u>67</u> that (X) (we) last saw the deceased alive on <u>6 Aug</u> 19 <u>67</u> and that death occurred at <u>2:43 M</u> from causes and on the date stated above.											
22a. SIGNATURE <i>Ira A. Gould</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6 August 67				
22c. PHYSICIAN'S NAME (Type) IRA A. GOULD, CAPT USAF MC					22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/10/67		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR <i>Charles Judge</i> ADDRESS Falls Church F. H. Falls Church, Va.					25a. REC'D BY REGISTRAR DATE AUG 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

11-11

CERTIFICATE OF DEATH

11-11

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11411

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 3825 Hamilton St.	
3. NAME OF DECEASED (Type or print) First Middle Last James H. Hurd		4. DATE OF DEATH Month Day Year 8 3 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Hurd		14. MOTHER'S MAIDEN NAME Cora Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 236-09-8121	
17. INFORMANT Wife		18. ADDRESS Same as Item 2.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 4201 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ last. } DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes over 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction - 1963			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 8-3-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-5-67	
23c. NAME OF CEMETERY OR CREMATORY Highland Mem. Park		23d. LOCATION (City or Town) (County) (State) Fayette County, W. Va.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

11-11-11

11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

11-11-11 11-11-11 11-11-11

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11408

11412

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE 3 days c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLCREST HEIGHTS d. STREET ADDRESS 2600 AFTON ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) FUGENCIA MARCELINA JOHANSEN				4. DATE OF DEATH Month Day Year AUGUST 23 1967									
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Jan 1891		9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY NA				11. BIRTHPLACE (County & State, or foreign country) San Juan, Puerto Rico		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME UNKNOWN DeLeon				14. MOTHER'S MAIDEN NAME UNKNOWN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NA				16. SOCIAL SECURITY NO. 579-629-942				17. INFORMANT Carolyn Sonnemamm Address: Daughter Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) SEVERE PULMONARY INSUFFICIENCY DUE TO (c) POST OP INTESTINAL OBSTRUCTION										INTERVAL BETWEEN ONSET AND DEATH 1 Hr 72 Hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 21 Aug 1967 to 23 Aug 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 23 Aug 1967 , and that death occurred at M , from the causes and on the date stated above.													
22a. SIGNATURE Frank A. Camp M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 23 Aug 67							
22c. PHYSICIAN'S NAME (Type) FRANK A. CAMP, MAJ, USAF MC						22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/28/67		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Wilhelm 4308 Suitland Road, Suitland, Maryland						25a. REC'D BY REGISTRAR DATE AUG 28 1967						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-1-12

PRINCE GEORGES HANLEYD BRINCE GEORGES

ANDREW AF BARE 3 days HILPERS HILPERS

USAF HOSPITAL ANDREW 1000 AFCH ST

TUGENTIA MARCELINA JOHANNES

AUGUST 19

FRANKE EAB 10 Jan 1941

HOUSEWIFE WA SAN JUAN, FORTIN RENO USA

UNKNOWN Delson UNKNOWN

NO WA 270-229-292 Carolyn Sommer

CARDIO ARREST

SEVERE PULMONARY INSUFFICIENCY

POST OF INTESTINAL OBSTRUCTION

21 Aug 23 Aug 27 Aug

1950

FRANK A. CAMP, MAJ. USAF, WASH DC 20331
USAF Hospital Andrews

ARRIVAL Arlington National Cemetery, Arlington, Virginia

4300 Solstead Road, Solstead, Maryland
Robert E. Wilson Funeral Home
AUG 2 1951

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11409

11413

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b Hyattsville Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY VIRGINIA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		d. STREET ADDRESS 2805 - 31st Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILDRED D. Kelley		4. DATE OF DEATH Month August Day 19 Year 1967		5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/13/1901		9. AGE (In years lost birthday) yrs. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Treasury Dept. U.S. Gov't		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? United States, D.C.		13. FATHER'S NAME J. B. Ouliv		14. MOTHER'S MAIDEN NAME Edna A. Spencer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 577-40-6296		17. INFORMANT Husband - same as above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 331X DUE TO Cerebral Vascular Acc Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis (b) 18 mo. (c) 15+ yrs.		INTERNAL BETWEEN ONSET AND DEATH 2 mos.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) in an infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) in an infection		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 1841 Col. Rd., N. W. D.C.		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2 , 19 65 , to 8/19 , 19 67 that (I) (we) last saw the deceased alive on 8/18 1967, and that death occurred at 2:30 AM, from causes and on the date stated above		22a. SIGNATURE E. H. Ascherbach, M.D.		22b. DATE SIGNED 8/19/67		22c. PHYSICIAN'S NAME (Type) E. H. Ascherbach, M.D.		22d. ADDRESS 1841 Col. Rd., N. W. D.C.		22e. REGISTRAR'S SIGNATURE Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/21/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.		24. FUNERAL DIRECTOR The S.H. Hines Co.		25a. REC'D BY REGISTRAR AUG 21 1967			

1918

CERTIFICATE OF DESIGN

Serial

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

100-1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11410													
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Md b. COUNTY Prince Georges							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) cheverly						c. LENGTH OF STAY IN 1b 6 mos							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2501 LAKE AVE						d. STREET ADDRESS 5317 Chesapeake Rd							
3. NAME OF DECEASED (Type or print) First Middle Last HAZEL LAVINA KEMERER						4. DATE OF DEATH Month Day Year Aug 13 1967							
5. SEX F		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 9 1901		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk typist				10b. KIND OF BUSINESS OR INDUSTRY Public Health Export PA				11. BIRTHPLACE (County & State, or foreign country) 23 A		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Obediah Hill						14. MOTHER'S MAIDEN NAME Ada Belle Thompson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. 173-16-7856						17. INFORMANT Address daughter Mrs Mildred Duquette	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 1538 DUE TO CARCINOMA ATOSIS Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO CARCINOMA OF COLON 1 1/2 yrs 3 1/2 yrs													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 19 52 to 8/13 1967 that (I) (we) last saw the deceased alive on 8/13 1967, and that death occurred at 5 AM, from the causes and on the date stated above.													
22a. SIGNATURE Norman A. Conner M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 8/13/67				
22c. PHYSICIAN'S NAME (Type) NORMAN DONATI CONNER						22d. ADDRESS 3503 Penny St Mt Rainier Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug 16 1967		23c. NAME OF CEMETERY OR CREMATORY Hills Church Cemetery				23d. LOCATION (City, town or county) (State) Franklin Township, Wmd, Pa			
24. FUNERAL DIRECTOR'S SIGNATURE F. Laschi Sons						ADDRESS 1640 Hyattsville, Md		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE AUG 15 1967							

1942

From the Department of the Interior
Bureau of Land Management
Washington, D. C.
Dear Sir:
The following is a list of the
lands which are being
considered for disposal
under the provisions of the
Act of March 3, 1909,
Chapter 110, 35 Stat.
226, as amended.
The lands are located in
the State of California
and are being offered for
sale at public auction
on the 1st day of May, 1942.
The lands are being offered
for sale at a minimum bid
of \$100.00 per acre.
The lands are being offered
for sale at a minimum bid
of \$100.00 per acre.
The lands are being offered
for sale at a minimum bid
of \$100.00 per acre.

Very truly yours,
Director
Bureau of Land Management
Washington, D. C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

Items 18 & 21

film #395
12-8-67 mt

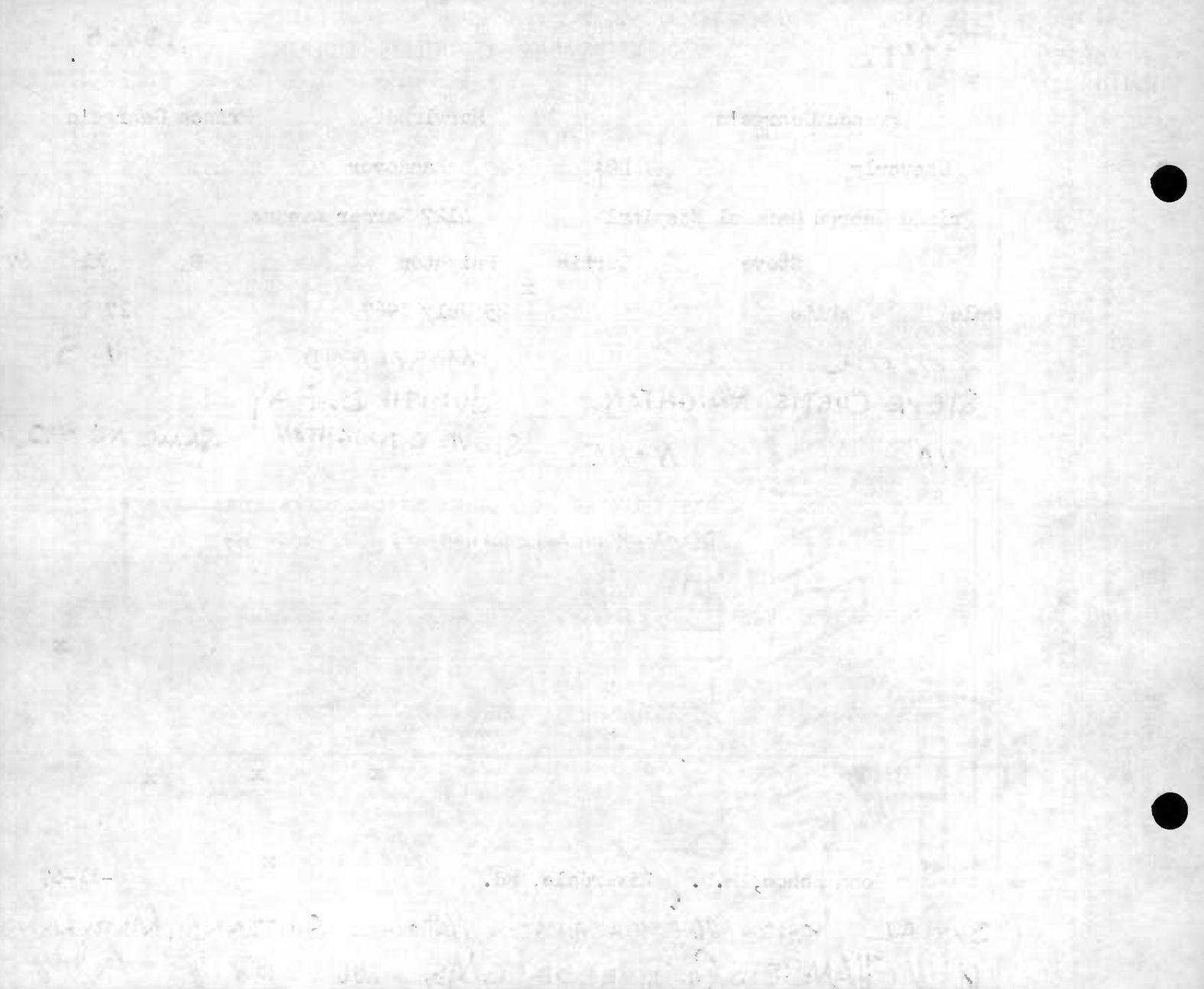
11411

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11415

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4127 Warner Avenue	
3. NAME OF DECEASED (Type or print) Steve Curtis Knighton		4. DATE OF DEATH Month 8 Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) yrs. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
13. FATHER'S NAME STEVE CURTIS KNIGHTON		14. MOTHER'S MAIDEN NAME JUDITH D. FAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT STEVE C KNIGHTON		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic pulmonary edema, bilateral, severe 7730 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Etiology undetermined (c) SD11		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 8-11-67	
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-12-1967	
23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, Md.		25a. REC'D BY REGISTRAR AUG 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11416

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton	
c. LENGTH OF STAY IN lb 44 Days		d. STREET ADDRESS 7600 Fontainebleau Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara B Korthaus		4. DATE OF DEATH Month Day Year 8 21 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Aug. 1882
9. AGE (In years last birthday) 84 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Grapperhaus		14. MOTHER'S MAIDEN NAME Josephine Temmerman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 270 05 9342B	
17. INFORMANT Korthaus		Address Albert J Korthaus New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 450.0 DUE TO And cerebral artery insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) From generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of left hip			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 6-27- 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) same as #2
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 8-21-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 23, 1967	23c. NAME OF CEMETERY OR PLACE OF INTERMENT National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church Fairfax Va
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1111

1111

1

[Handwritten signature]

FOR STATE
HEALTH DEPT.

11413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 40 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Rt. 2, Box 56	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence		4. DATE OF DEATH Month 8 Day 7 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-1874
9. AGE (In years lost birthday) 93 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-56-0425	
17. INFORMANT MARGARET WATERHOUSE, GREENBELT, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right hip -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 6-29- '67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 8-7-67	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-9-67	
23c. NAME OF CEMETERY OR CREMATORY TRINITY MEM. GARDENS		23d. LOCATION (City or Town) (County) (State) WALDORF, CHARLES, MD.	
24. FUNERAL DIRECTOR The Hunt Funeral Home, WALDORF, MD		25a. REC'D BY REGISTRAR AUG 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd

1st and 2nd



1st and 2nd

1st and 2nd

1st and 2nd

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11419

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 3303 Sudlersville South	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wallace Middle G Last Lee		4. DATE OF DEATH Month 8 Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Aug. 1912
9. AGE (In years last birthday) 54 yrs.		10. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Lee		14. MOTHER'S MAIDEN NAME Effie Mc Kinney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 577-36-2355	
17. INFORMANT Martha Ann Lee Address 3303 Sudlersville South Laurel, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes - over 7 yrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 8-16-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Aug 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.
24. FUNERAL DIRECTOR C. Glen Carter, 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR AUG 18 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

523

1903

• • • • •

23 . 7:534

5725-3-57

• *Journal of the American Medical Association* 283:1211-1212, 2000

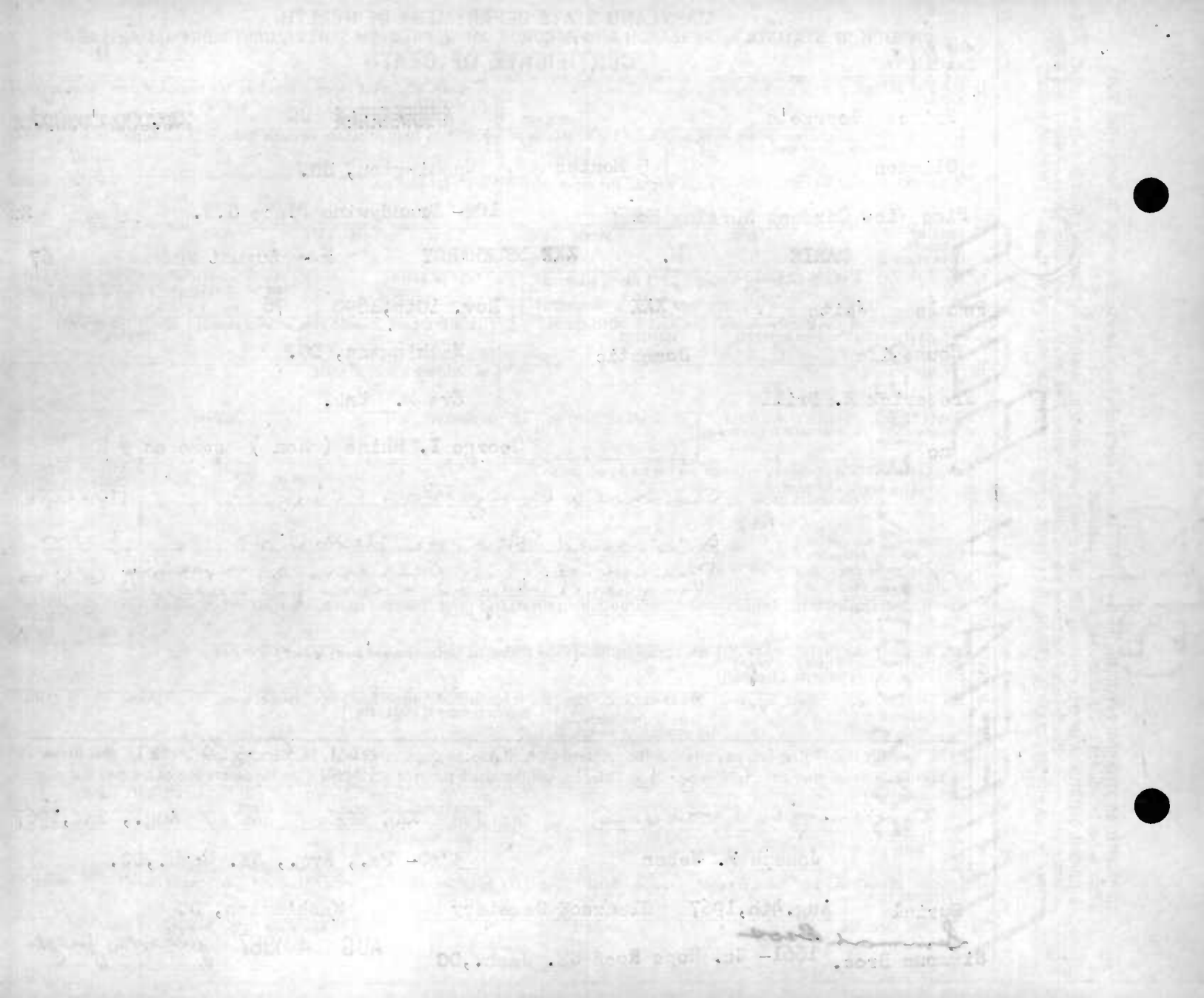
• • • • •

• 2013-2014

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11415					11420				
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELETED DO b. COUNTY DELETED				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton			c. LENGTH OF STAY IN 1b 5 Months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, DC. 47-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pine View Gardens Nursing Home					d. STREET ADDRESS 102- Brandywine Place S.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARIE M. XXX LEUKHARDT					4. DATE OF DEATH August 2nd 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10th, 1890		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick R. Brill					14. MOTHER'S MAIDEN NAME Eva M. Unk.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT George I. Rhine (Son) Address same as # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> 2927 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Hemiparesis</u> DUE TO (c) <u>Preterminal Anemia requiring frequent blood transfusions</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 1 week 3 yrs 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1964, to <u>Aug. 2</u> , 1967, that (I) (we) last saw the deceased alive on <u>Aug. 1</u> 1967, and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>F. Joseph Weber</u>					22b. DATE SIGNED Aug., 2nd, 1967				
22c. PHYSICIAN'S NAME (Type) Joseph F. Weber					22d. ADDRESS 3230- Pa., Ave., SE. Wash., DC.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug. 4th, 1967		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town or county) (State) Washington, DC		
24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS 1661- Gd. Hope Road SE. Wash., DC					25a. REC'D BY REGISTRAR AUG 4 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11416

11421

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 4003 51st St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Emerson Harold Lewis			4. DATE OF DEATH Month Day Year 8 5 19 67		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Sept 1917		9. AGE (In years lost birthday) yrs. 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Walter Lewis			14. MOTHER'S MAIDEN NAME Lora Bailey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 236 10 9190		17. INFORMANT Gladys Lewis Address Bladensburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 8720 IMMEDIATE CAUSE (a) Salicylate intoxication DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 24 HRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took overdose of aspirin for headache.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8-4-67 p.m. a.m. & p.m.		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) (County) (State) Same as #2			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8-5-67	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Aug 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Tyree Funeral Home	
		23d. LOCATION (City or Town) (County) (State) Oak Hill Fayette Co West Va			
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 9 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

11417

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7401 Flower Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise First Middle Last Low		4. DATE OF DEATH Month Day Year Aug. 3, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1924 9. AGE (In years last birthday) 43 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Georgia
13. FATHER'S NAME Everett Hurt		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME Unknown	
16. SOCIAL SECURITY NO.		17. INFORMANT Mother Mrs. E. R. Hurt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 332X IMMEDIATE CAUSE (a) Car brooves over accident DUE TO Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Pneumonia (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from July 28, 1967 , to Aug. 3, 1967 , that (x) (we) last saw the deceased alive on Aug. 3, 1967 , and that death occurred at 7:07 PM , from causes and on the date stated above.			
22a. SIGNATURE William B. Gunther M.D.		22b. DATE SIGNED Aug. 4, 1967	
22c. PHYSICIAN'S NAME (Type) William B. Gunther, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-5-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR Robert A. Humphrey Bethesda M.D.		25a. REC'D BY REGISTRAR AUG 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100

RECEIVED

Prison Records

Prison

Prison Records

Prison

Prison

Prison

Prison Records

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

Prison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11418		11423	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights, Maryland	
c. LENGTH OF STAY IN 1b 8/8/67 to 8/9/67		d. STREET ADDRESS 2431 Iverson Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens Health Care Center P 7401 Stuart Lane, Clinton, 20735		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle A. Last Loy		4. DATE OF DEATH Month August Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1894
9. AGE (In years, last birthday) 72 yrs.		IF UNDER 1 YEAR Months 19 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Hagan		14. MOTHER'S MAIDEN NAME Kathern Flarighty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-5655-	
17. INFORMANT Pine View Gardens, Clinton, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Collapse DUE TO (b) Cerebral vascular accident DUE TO (c) Arteriosclerosis, generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-8 , 1967, to 8-16 , 1967, that (I) (we) last saw the deceased alive on 8-16 , 1967, and that death occurred at 11:30 M, from causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lapan, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPAN, M.D.		22d. ADDRESS CLINTON, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/19/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR AUG 18 1967 DATE	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO THE ORDER OF THE
TREASURER OF THE
UNITED STATES OF AMERICA
FOR DEPOSIT TO THE
TREASURY OF THE
UNITED STATES OF AMERICA
FOR THE PAYMENT OF
THE DEBT OF THE
UNITED STATES OF AMERICA
FOR THE PAYMENT OF
THE DEBT OF THE
UNITED STATES OF AMERICA

Handwritten signature

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11419		11424	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE	c. LENGTH OF STAY IN 1b 6 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 5513 BELFAST DRIVE, S.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First PARK Middle VINCENT Last MACKALL		4. DATE OF DEATH Month AUGUST Day 20 Year 1967	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 AUG 1935
9. AGE (In years last birthday) yrs. 32		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CHESTER, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE E. MACKALL		14. MOTHER'S MAIDEN NAME FLEDA McMILLIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES Feb 58- Mar 65		16. SOCIAL SECURITY NO. 201-28-9976	
17. INFORMANT MRS. SUZANN B. MACKALL, 5513 BELFAST DR., S.E., OXON HILL, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia pneumococcal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hodgkins Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) XXXXXX attended the deceased from 14 August , 19 67 , to 20 August , 19 67 , that (I) XXXX last saw the deceased alive on 20 August , 19 67 , and that death occurred at 1:53 A M, from causes and on the date stated above.			
22a. SIGNATURE Walter Myalls M.D.		22b. DATE SIGNED 20 Aug 1967	
22c. PHYSICIAN'S NAME (Type) CAPT. WALTER A. MYALLS		22d. ADDRESS 4251-2 WILMINGTON DR., ANDREWS AFB, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/23/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND MARYLAND		25a. REC'D BY REGISTRAR AUG 23 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

REPORT OF THE

COMMISSIONER

OF THE

INTERNAL SECURITY

IN THE

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

1950

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

1950

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11420
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11425

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel General Hospital		d. STREET ADDRESS 3807 65th avenue,.	
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE MAGROGAN		4. DATE OF DEATH Month Day Year 8 10 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8, 1967
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland Pro George's
13. FATHER'S NAME Theodore J. Magrogan		14. MOTHER'S MAIDEN NAME Janet Kay Allen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Theodore J. Magrogan		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7733 Hyalin membrane disease of lungs DUE TO (b) ? Prematurity (6 wks pre.) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/9, 1967 to 8/10, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/10, 1967, and that death occurred at 1:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Frank J Weaver		22b. DATE SIGNED Aug 10, 1967	
22c. PHYSICIAN'S NAME (Type) Frank J Weaver		22d. ADDRESS 320 Montgomery st Laurel, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City, town or county) (State) Wheaton Montgomery Md.
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE AUG 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

7-270141

STATE OF NEW YORK

1907

1907

1907

1907

THEODORE

1907

THEODORE

1907

THEODORE

1907

1907

1907

1907

1907

1907

11421

CERTIFICATE OF DEATH

11426

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Nursing Home</u>		d. STREET ADDRESS <u>2010 Ft. Davis St. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>L.</u> Last <u>McCartor</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer - Western High School</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>70</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John McCartor</u>		14. MOTHER'S MAIDEN NAME <u>Julia Gaynor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>519-60-7443</u>	17. INFORMANT <u>Mrs Mary McCartor</u> Address <u>2010 Ft. Davis St. S.E.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966, 19</u> to <u>23 Aug., 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 21</u> <u>1967</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Thibodeau</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9-23-1967</u>
22c. PHYSICIAN'S NAME (Type) <u>J. H. Thibodeau</u>		22d. ADDRESS <u>3112 AIA Ave. S.E. DC 20020</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>
24. FUNERAL DIRECTOR <u>James T. Ryan</u>		25a. REC'D BY REGISTRAR <u>317 Pa Ave. S.E. Washington, D.C.</u>	25b. REGISTRAR'S SIGNATURE <u>James T. Ryan</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED
JAN 10 1941
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY
FROM THE CHIEF, BUREAU OF ENTOMOLOGY
SUBJECT: [illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing entomological findings or administrative matters.]

RECEIVED
JAN 10 1941
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

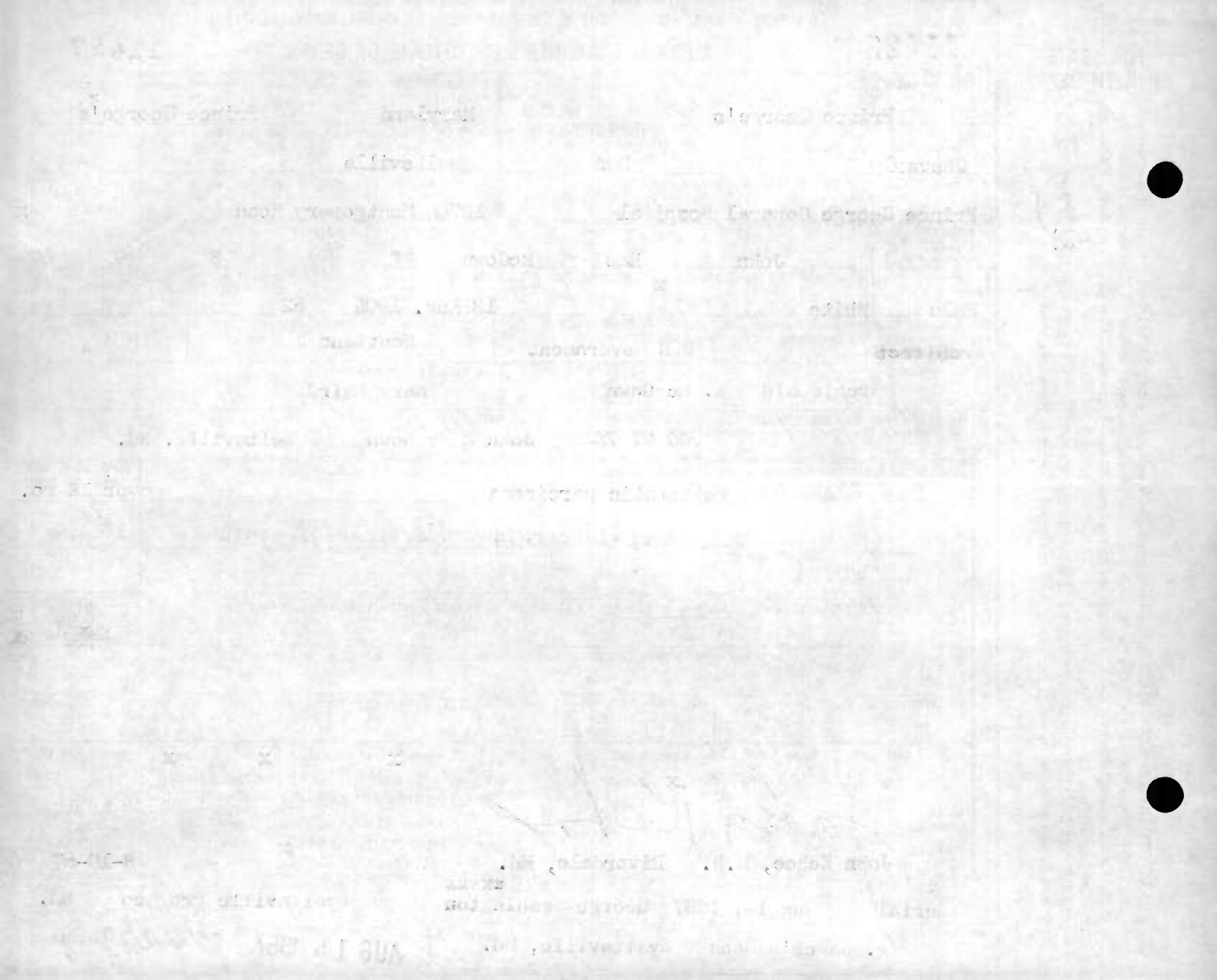
Very truly yours,
[Signature]

Enclosed for the Bureau of Plant Industry are [illegible] copies of [illegible] report.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-200. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 397 2-14-67		MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11422	
11422		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
11427		11427	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 10704 Montgomery Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Rae McGown Sr		4. DATE OF DEATH Month Day Year 8 9 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Aug. 1904
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Archiebald K. Mc Gown		14. MOTHER'S MAIDEN NAME Mary Laird	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 050 07 7830	
17. INFORMANT John R Mc Gown		Address Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 143X IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epidermoid carcinoma of floor of mouth DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH over 18 mo. 18 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED 3 While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 8-10-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 14, 1967	
23c. NAME OF CEMETERY OR CREMATOR George Washington		23d. LOCATION (City or Town) (County) (State) Hyattsville Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR AUG 15 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #11, taken from birth ph

11423

CERTIFICATE OF DEATH

11428

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 hrs. 6 mins	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last McGregor		4. DATE OF DEATH Month Aug. Day 30 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME William McGregor		14. MOTHER'S MAIDEN NAME Sharon Marie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) prematurity DUE TO (b) Atelectasis of lungs, bilateral. DUE TO (c) lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 30, 1967 , to Aug. 30, 1967 , that (I) (xxx) last saw the deceased alive on Aug. 30, 19 67 , and that death occurred at 10:45 PM from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Manuel Porres, M. C.		22d. ADDRESS 6315 Landover Rd. Landover, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9/2/67	
23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly PG Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin.		25a. REC'D BY REGISTRAR SEP 6 1967	
25b. REGISTRAR'S SIGNATURE 			

11-13

Prince George

University

Prince George General Hospital

541-55th Ave.

Male

White

Aug. 30, 1967

William McGowan

Sharon Marie Smith

11-13

Aug. 30, 1967

Aug. 30, 1967

10:55

32

6111 Landown Rd. Langford, Maryland

Prince George, N. C.

Prince George, N. C.

Prince George, N. C.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11424

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11429

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4627 Lewis Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank M McIntyre				4. DATE OF DEATH Month 8 Day 9 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years lost birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Cox oil Co.		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence A. McIntyre				14. MOTHER'S MAIDEN NAME Gertrude Fallon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 091-05-7318		17. INFORMANT Ludwika McIntyre Address 2109 Suitland Ter. Wash. D.C. S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH days days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Fell down steps at apartment house.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 9:00pm 7-28- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 8-10-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/14/67		23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City or town) (County) (State) Staten Island Richmond NY	
24. FUNERAL DIRECTOR Jos. Gawles Sons Inc.				25a. REC'D BY REGISTRAR ADDRESS 5130 Wisconsin Ave. N.W. Washington D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE AUG 14 1967			

MEDICAL CERTIFICATION

021-03-731214-14 McInyre, N.Y.
Gertrude Hallon
2103 Eastland Ter.
N.Y.
U.S.A.

St. Peters
Staten Island
Richmond N.Y.
1-1-73

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11425					11430				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) p. STATE Maryland h. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 6918 Palmer Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Lurlene Middle C. Last McKenney					4. DATE OF DEATH Month Aug. Day 12, Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1899		9. AGE (In years lost birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Tennessee			12. CITIZEN OF WHAT COUNTRY? U S A.		
13. FATHER'S NAME Wm S Burton				14. MOTHER'S MAIDEN NAME Susan Feathers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 579 20 1163		17. INFORMANT Robert L Roberts Address Alexandria, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO (b) Coronary Heart Disease DUE TO (c) Severe arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH none	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 9, 1967 to Aug. 12, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 9, 1967 , and that death occurred at 11:51 P.M. from causes and on the date stated above.									
22a. SIGNATURE Max M. Herzberg				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Max M. Herzberg, M. D.				22d. ADDRESS 3308 Dodge Rk. Rd. Landover, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 17, 1967		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery			23d. LOCATION (City or Town) (County) (State) Bladensburg Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 18 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jager	

OFFICE OF THE DIRECTOR

1. Name of the person or organization to whom the report is made	2. Name of the person or organization making the report	3. Title of the report	4. Date of the report
5. Place of the report	6. Name of the person or organization making the report	7. Title of the report	8. Date of the report
9. Name of the person or organization making the report	10. Title of the report	11. Date of the report	12. Name of the person or organization making the report
13. Title of the report	14. Date of the report	15. Name of the person or organization making the report	16. Title of the report
17. Date of the report	18. Name of the person or organization making the report	19. Title of the report	20. Date of the report
21. Name of the person or organization making the report	22. Title of the report	23. Date of the report	24. Name of the person or organization making the report
25. Title of the report	26. Date of the report	27. Name of the person or organization making the report	28. Title of the report
29. Date of the report	30. Name of the person or organization making the report	31. Title of the report	32. Date of the report
33. Name of the person or organization making the report	34. Title of the report	35. Date of the report	36. Name of the person or organization making the report
37. Title of the report	38. Date of the report	39. Name of the person or organization making the report	40. Title of the report
41. Date of the report	42. Name of the person or organization making the report	43. Title of the report	44. Date of the report
45. Name of the person or organization making the report	46. Title of the report	47. Date of the report	48. Name of the person or organization making the report
49. Title of the report	50. Date of the report	51. Name of the person or organization making the report	52. Title of the report
53. Date of the report	54. Name of the person or organization making the report	55. Title of the report	56. Date of the report
57. Name of the person or organization making the report	58. Title of the report	59. Date of the report	60. Name of the person or organization making the report
61. Title of the report	62. Date of the report	63. Name of the person or organization making the report	64. Title of the report
65. Date of the report	66. Name of the person or organization making the report	67. Title of the report	68. Date of the report
69. Name of the person or organization making the report	70. Title of the report	71. Date of the report	72. Name of the person or organization making the report
73. Title of the report	74. Date of the report	75. Name of the person or organization making the report	76. Title of the report
77. Date of the report	78. Name of the person or organization making the report	79. Title of the report	80. Date of the report
81. Name of the person or organization making the report	82. Title of the report	83. Date of the report	84. Name of the person or organization making the report
85. Title of the report	86. Date of the report	87. Name of the person or organization making the report	88. Title of the report
89. Date of the report	90. Name of the person or organization making the report	91. Title of the report	92. Date of the report
93. Name of the person or organization making the report	94. Title of the report	95. Date of the report	96. Name of the person or organization making the report
97. Title of the report	98. Date of the report	99. Name of the person or organization making the report	100. Title of the report

REPORT OF THE DIRECTOR OF THE BUREAU OF THE ARMY

REPORT OF THE DIRECTOR OF THE BUREAU OF THE ARMY

REPORT OF THE DIRECTOR OF THE BUREAU OF THE ARMY

REPORT OF THE DIRECTOR OF THE BUREAU OF THE ARMY

REPORT OF THE DIRECTOR OF THE BUREAU OF THE ARMY

REPORT OF THE DIRECTOR OF THE BUREAU OF THE ARMY

REPORT OF THE DIRECTOR OF THE BUREAU OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11420				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11431			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges MaxxRainier							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		16-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4206 Kaywood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Andrew Meldrum				4. DATE OF DEATH Month Aug. Day 5 Year 1967							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1900	9. AGE (In years last birthday) yrs. 66	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Belgium Embassy		10b. KIND OF BUSINESS OR INDUSTRY Embassy		11. BIRTHPLACE (County & State, or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U S A.					
13. FATHER'S NAME Thomas Meldrum				14. MOTHER'S MAIDEN NAME ?							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Catherine Grabo		Address Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA, BOTH LUNGS DUE TO (c) ARTERIO SCLEROTIC HEART DISEASE								INTERVAL BETWEEN ONSET AND DEATH 36 Hours 6 DAYS 6 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CIRRHOSIS OF LIVER; DIABETES MELLITUS								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 29, 1967 that (I) was saw the deceased alive on Aug 5, 1967 , and that death occurred at 1:05 AM on Aug 5, 1967 from causes and on the date stated above.											
22a. SIGNATURE Samuel J. N. Sugar				22b. DATE SIGNED 8/5/67		22c. PHYSICIAN'S NAME (Type) Samuel J. N. Sugar, M. D.		22d. ADDRESS 4637 Eastern Ave., Washington 18, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 9 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Usual Residence	
Cause of Death		Date of Death	
Place of Death		Signature of Physician	
Signature of Registrar		Date of Registration	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turbotville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hardie Ikeler Merrell						4. DATE OF DEATH Month 8 Day 16 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-1907		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter				10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Turbotville, Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orin J. Merrill						14. MOTHER'S MAIDEN NAME Vinnie Ikeler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Herbert E. Barr				Address Watsontown, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH over 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe, M.D.						22. DATE SIGNED 8-17-67					
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-20-67		23c. NAME OF CEMETERY OR CREMATORY Turbotville Cem.		23d. LOCATION (City or Town) (County) (State) Turbotville Pa.		25a. REC'D BY REGISTRAR DATE AUG 21 1967			
24. REMOVAL Joseph Gawlers Sons		ADDRESS 5130 Wisc. Ave NW		25b. REGISTRAR'S SIGNATURE Charles Judge							
Wash, D. C.											

11/15/2011

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

0.1

10

1

0 100 200 300 400 500 600 700 800 900 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

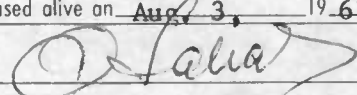

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11428

11433

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN Tb 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaver Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1513 - 52nd Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Patience T. Metcalf		4. DATE OF DEATH Month Day Year August 3, 1967	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-14
9. AGE (In years last birthday) yrs. 53		10. IF UNDER 1 YEAR Months Days Hours Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Horace Williamson		14. MOTHER'S MAIDEN NAME Alice 7	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ernest Metcalf		Address 1513 52nd Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Severe bilateral confluent Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Fatty Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from July 31, 1967 , to Aug. 3, 1967 , that (I) (we) saw the deceased alive on Aug. 3, 1967 , and that death occurred at 1:05 P.M. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED Aug. 4, 1967	
22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M. D.		22d. ADDRESS 6001 Landover Rd. Cheverly, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/8/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park	23d. LOCATION (City or Town) (County) (State) Huntsville, Md.
24. FUNERAL DIRECTOR John T. Stewart		25a. REC'D BY REGISTRAR 4001 Benjamin Washington, D.C.	
25b. REGISTRAR'S SIGNATURE 		DATE AUG 8 1967	

STATE OF TEXAS

County of ...

City of ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11429

CERTIFICATE OF DEATH

11434

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1940 Brightseat Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Morris Middle K. Last Miller				4. DATE OF DEATH Month August Day 26 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/14/07	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Department store		11. BIRTHPLACE (County & State, or foreign country) West Va	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME George W. Miller			
14. MOTHER'S MAIDEN NAME Elva Chapman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. 235 01 5568				17. INFORMANT Hazel M Miller Address Landover, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS, SEPTICEMIA DUE TO 5411 (b) RHOLECYSTODUODENAL FISTULA, SUBHEPATIC ABSCESS. (c) PERFORATED DUODENAL ULCER						INTERVAL BETWEEN ONSET AND DEATH UNDETERMINED	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1, 1967 , to August 26, 1967 , that (I) (we) last saw the deceased alive on August 26, 1967 , and that death occurred at 7:30AM , from causes and on the date stated above.							
22a. SIGNATURE Felix Flores M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/26/67	
22c. PHYSICIAN'S NAME (Type) FELIX FLORES, M.D.				22d. ADDRESS 16113 LAUREL RIDGE DRIVE LAUREL, MD-20810			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 29 1967	
				25b. REGISTRAR'S SIGNATURE J Charles Judge			

MEDICAL CERTIFICATION

PERCY THOMPSON, FIVE, SUBVARIANT
BAPTIST
PERCY THOMPSON, FIVE, SUBVARIANT
BAPTIST
PERCY THOMPSON, FIVE, SUBVARIANT
BAPTIST

FELIX FLORES, MD.
Felix Flores MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11430

CERTIFICATE OF DEATH

11435

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5108 Bennings Road	
3. NAME OF DECEASED (Type or print) First Middle Last Harold L Milton		4. DATE OF DEATH Month Day Year Aug. 24 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1938
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years lost birthday) yrs. 29
10a. BIRTHPLACE (County & State, or foreign country) Culpeper Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LLOYD [REDACTED] MILTON		14. MOTHER'S MAIDEN NAME GRACE MILTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 579-56-8674		17. INFORMANT Address LLOYD MILTON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral confluent bronchopneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Aug. 22, 1967 to Aug. 24, 1967 , that (X) (we) last saw the deceased alive on Aug. 24, 1967 , and that death occurred at 6:30 AM , from causes and on the date stated above.			
22a. SIGNATURE RVS [Signature]		22b. DATE SIGNED Aug. 24, 1967	
22c. PHYSICIAN'S NAME (Type) Roger Ingham, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/27/67	23c. NAME OF CEMETERY OR CREMATORY Family Plot	23d. LOCATION (City or Town) (County) (State) Culpeper Va.
24. FUNERAL DIRECTOR M. M. Marshall		25a. REC'D BY REGISTRAR DATE AUG 28 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

THE WHITE OF EIGHT

Place names

Washington

Place names

George

2 days

Washington, D.C.

Prince George's General Hospital

6108 Building Road

Barbados

Milton

1958

Male Negro

George Milton

George Milton

George Milton

Unilateral conjunctivitis

Aug. 22, 1958

Aug. 24, 1958

Aug. 25, 1958

Prince George's General Hospital

Robert Graham, M.D.

George Milton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11431

CERTIFICATE OF DEATH

11436

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREENBELT NURSING HOME		d. STREET ADDRESS 4907 43rd avenue-	
3. NAME OF DECEASED (Type or print) First ROY Middle C Last MINER		4. DATE OF DEATH Month 8 Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet maker		10b. KIND OF BUSINESS OR INDUSTRY retired	9. AGE (In years last birthday) yrs. 86
11. BIRTHPLACE (County & State, or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cyrus Luckitt Miner		14. MOTHER'S MAIDEN NAME Jennie Koontz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Glady's Luther Hyattsville, Ind		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Congestive Heart Failure DUE TO (b) Intensive Osteocarcinoma of Colon DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-7 , 19 67 , to 8-19 , 19 67 , that (I) (we) lost saw the deceased alive on 8-19-67 19 67 , and that death occurred at 10:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Burton A. Johnson		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8-19-67
22c. PHYSICIAN'S NAME (Type) Burton A. Johnson		22d. ADDRESS Beltsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 22 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

1946

CENTRAL AIR OF DEATH

1946

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "DEATH" and "CENTRAL" are visible.]

[Faint, mostly illegible text and markings on the right side of the page, possibly bleed-through from the reverse side.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11432

11437

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District Of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 941 T Street, N.W.			
3. NAME OF DECEASED (Type or print) Richard First Monroe Middle Last				4. DATE OF DEATH Month 8 Day 15 Year 19 67			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 Jan. 1942	
9. AGE (In years lost birthday) yrs. 25		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington DC	
13. FATHER'S NAME Lee Monroe				14. MOTHER'S MAIDEN NAME Marie Roe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Marie Roe Address 1208-6 St NE Wash DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fractures and lacerations DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which struck tree			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:40am p.m. 8-15-1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Eastern Ave. & Sheriff Rd., N.E., Wash., D.C.	
20f. (City or town) (County) (State) Washington, D.C.				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 8-16-67				23. SIGNATURE John Kehoe, M.D. M.D.			
23a. BURIAL, CREMATION, or other disposition Latney Funeral Home				23b. DATE THEREOF 8-19-1967		23c. NAME OF CEMETERY Harmony Memorial Pr. Geo. County, Md	
23d. LOCATION (City or town) (County) (State) Washington DC				24. FUNERAL DIRECTOR Latney Funeral Home		25a. REC'D BY REGISTRAR AUG 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. ADDRESS 3831 2nd Ave Wash DC			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 395 11-27-67 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11433 Item #11 & 13 info, taken from birth cert. 11438											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS RFD Box 3416 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Boy Moore						4. DATE OF DEATH August 29 19 67					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/27/67		9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cheverly, P. G. Co.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Kenneth Chapman						14. MOTHER'S MAIDEN NAME Mary C. Moore					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 795.5 IMMEDIATE CAUSE (a) Undetermined (sudden death in fancy) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Pending histologic examination DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/27 , 19 67 , to 8/29 , 1967, that (I) (we) last saw the deceased alive on 8/29 , 19 67 , and that death occurred at 6 A. M, from causes and on the date stated above.											
22a. SIGNATURE Dr. Harold Y. Finck						22b. DATE SIGNED 8/29/67		22c. PHYSICIAN'S NAME (Type) Dr. Harold Y. Finck			
22d. ADDRESS 11825 New Hampshire Ave., Silver Spr.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 9/2/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland			
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md.						25a. REC'D BY REGISTRAR SEP 6 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

VR A15
25M 1/67

7-279686

1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11434			
CERTIFICATE OF DEATH			
11439			
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Zip 20785	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2803 Nicholson Street	
3. NAME OF DECEASED (Type or print) Frank L. Moore		4. DATE OF DEATH Month August Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/36
9. AGE (In years last birthday) yrs. 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Safeway Store	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Harry Moore		14. MOTHER'S MAIDEN NAME Frances West	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES NOBMAN		16. SOCIAL SECURITY NO. 577 401914	
17. INFORMANT Mrs. Frances A. Moore, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Carcinoma of the right lung; with DUE TO (b) generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from 4-22 , 19 67 , to 8-9 , 19 67 , that (I) we saw the deceased alive on 8-9 , 19 67 , and that death occurred at 12:35M , from causes and on the date stated above.			
22a. SIGNATURE Aaron Deitz		22b. DATE SIGNED 8-5-67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland
24. FUNERAL DIRECTOR W. W. CHAMBERS CO.		25a. REC'D BY REGISTRAR AUG 7 1967	
ADDRESS Riverdale, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11435		11440	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA	
c. LENGTH OF STAY IN lb 2 MONTHS		83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAFHOSP ANDREWS		d. STREET ADDRESS 5606 JUSTIS PLACE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD FREDERICK MOORE		4. DATE OF DEATH Month Day Year AUGUST 12 19 67	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1922
9. AGE (In years lost birthday) yrs. 45		IF UNDER 1 YEAR Months Days Hours Min. - - - -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE	
11. BIRTHPLACE (County & State, or foreign country) WARREN, MAINE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY MOORE		14. MOTHER'S MAIDEN NAME GLADYS OLIVER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 16 Sep 1940		16. SOCIAL SECURITY NO. 004-16-5580	
17. INFORMANT Wife and Medical/Personnel Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer to liver and brain DUE TO (b) primary cancer of cardia of stomach DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to 12 Aug , 19 67 , that (I) (we) lost the deceased on 12 Aug , 19 67 , and that death occurred at 0720 AM from causes on the date stated above.			
22a. SIGNATURE Frank A. Camp		22b. DATE SIGNED 12 Aug 67	
22c. PHYSICIAN'S NAME (Type) FRANK A. CAMP		22d. ADDRESS USAF Hosp Andrews, AAFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Rem.		23b. DATE THEREOF 8-18-1967	
23c. NAME OF CEMETERY OR CREMATORY Village Cem.		23d. LOCATION (City or Town) (County) (State) Thonaston, Maine	
24. FUNERAL DIRECTOR Falls Church Funeral Home		25a. REC'D BY REGISTRAR AUG 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEMORANDUM FOR THE DIRECTOR

100-100000

RE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health Department prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

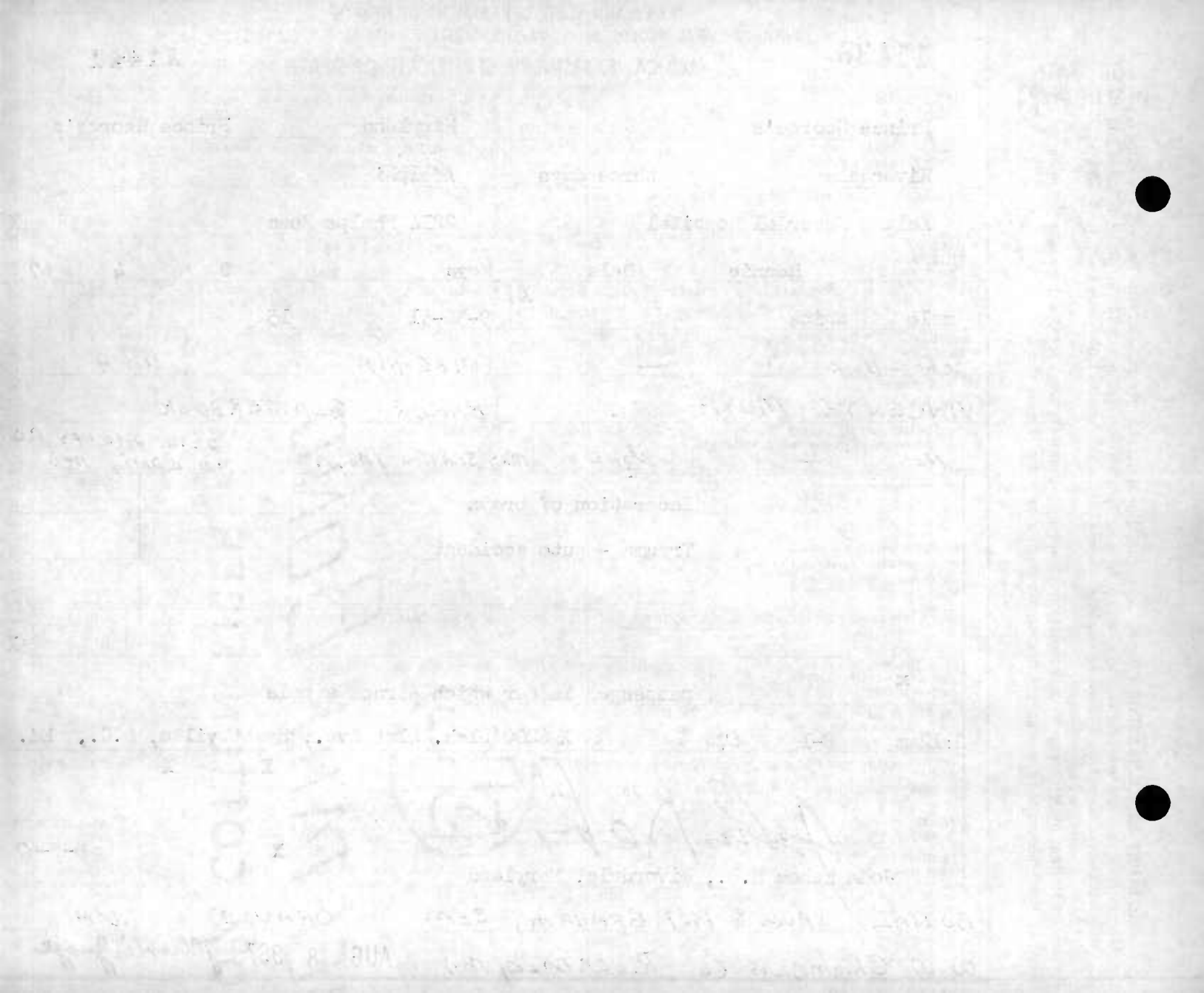
11436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11441

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b three days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 2214 Phelps Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ronnie Dale Moya			4. DATE OF DEATH Month 8 Day 4 Year 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-51	9. AGE (In years lost birthday) 15 yrs.	IF UNDER 1 YEAR Months 1 Days 4 Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL BOY		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME VINCENTE MOYA			14. MOTHER'S MAIDEN NAME BARBARA CLATTERBUCK		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS BARBARA MOYA Address 2214 PHELPS RD ADELPHI, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Laceration of brain DUE TO (b) Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) —					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) passenger in car which struck a pole			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:12am p.m. 8-1 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> ot work <input type="checkbox"/> ot work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6200 blk. 41st Ave., Hyattsville, P.G., Md.	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8-5-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 8 1967		23c. NAME OF CEMETERY OR CREMATORY GRAHAM, CEM	
23d. LOCATION (City or Town) (County) (State) ORANGE, VA		24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE AUG 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11437

11442

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 207 Addison Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry C. Naylor		4. DATE OF DEATH Month Aug. Day 18, Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21 1889
9. AGE (In years lost birthday) yrs. 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY County Gov.		11. BIRTHPLACE (County & State, or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Collier Naylor	
14. MOTHER'S MAIDEN NAME Katherine ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---	
16. SOCIAL SECURITY NO. ---		17. INFORMANT James W. Naylor Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs 5-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Jan 15, 1945 to Aug. 18, 1967 , that (I) (we) last saw the deceased alive on Aug. 18, 1967 , and that death occurred at 12:50M , from causes and on the date stated above.			
22a. SIGNATURE William Brainin M.D.		22b. DATE SIGNED 8/18/67	
22c. PHYSICIAN'S NAME (Type) WM BRAININ		22d. ADDRESS 614 Central Ave Capital Hill Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/22/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md.
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland, Road, Suitland, Maryland		25a. REC'D BY REGISTRAR OATE AUG 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 DIVISION OF RECORDS
 OFFICE OF THE REGISTRAR
 1000 PENNSYLVANIA AVENUE, N.W.
 WASHINGTON, D.C. 20034
 TELEPHONE: 204-4331
 FAX: 204-4331

The following information was obtained from the records of the Department of Health, Bureau of Vital Statistics, Division of Records, Office of the Registrar, 1000 Pennsylvania Avenue, N.W., Washington, D.C. 20034, on the date of the request.

Name: [Name]
 Date of Birth: [Date]
 Sex: [Sex]
 Race: [Race]
 Marital Status: [Status]
 Place of Birth: [Place]
 Country of Birth: [Country]
 Date of Death: [Date]
 Cause of Death: [Cause]
 Place of Death: [Place]
 Country of Death: [Country]

The above information was obtained from the records of the Department of Health, Bureau of Vital Statistics, Division of Records, Office of the Registrar, 1000 Pennsylvania Avenue, N.W., Washington, D.C. 20034, on the date of the request.

Date: [Date]
 Time: [Time]
 Signature: [Signature]
 Title: [Title]

The following information was obtained from the records of the Department of Health, Bureau of Vital Statistics, Division of Records, Office of the Registrar, 1000 Pennsylvania Avenue, N.W., Washington, D.C. 20034, on the date of the request.

Name: [Name]
 Date of Birth: [Date]
 Sex: [Sex]
 Race: [Race]
 Marital Status: [Status]
 Place of Birth: [Place]
 Country of Birth: [Country]
 Date of Death: [Date]
 Cause of Death: [Cause]
 Place of Death: [Place]
 Country of Death: [Country]

The above information was obtained from the records of the Department of Health, Bureau of Vital Statistics, Division of Records, Office of the Registrar, 1000 Pennsylvania Avenue, N.W., Washington, D.C. 20034, on the date of the request.

Date: [Date]
 Time: [Time]
 Signature: [Signature]
 Title: [Title]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11438

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11443

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 15 DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside d. STREET ADDRESS 1129 49th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Albert Leo Northedge		4. DATE OF DEATH Month Day Year 8 22 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-05
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Maryland State Gov.	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Ruth E. Northedge		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Heart Disease DUE TO (c) over 6 mo.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland EXAMINER'S NAME (Type)		22. DATE SIGNED 8-23-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/26/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Md
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR AUG 24 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

11439

CERTIFICATE OF DEATH

11444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 47-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (Rural)		c. LENGTH OF STAY IN lb 7 1/2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 12 Logan Circle, N.W.	
3. NAME OF DECEASED (Type or print) Moses First Middle Last Oliver		4. DATE OF DEATH August 9, 19 67 Month Day Year	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/7/01 9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Oliver		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 579-18-2518	
17. INFORMANT decendent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 150X			INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.V.A. with left hemiplegia; hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/16/966 , to 8/9/ 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/9/1967 , and that death occurred at 8:00PM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 8/9/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-14-67	23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEMETERY	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR Phelps Funeral Home ADDRESS 3015-12th St.		25a. REC'D BY REGISTRAR DATE AUG 14 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

GENERAL INQUIRY

Prince Georges

Washington, D. C.

Logan Circle, N.W.

Oliver

Moran

11/1/01

S.C.

unknown

Edward Oliver

deceased

574-18-7516

Caricatures of the encephalitis

C.V.A. with left hemiparesis; hyperextension

12/1/01
8:00P

8/2/01

Glenn Dale Hospital
Glenn Dale, Md.

Mrs. Walter, M. D.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11445

FOR STATE
HEALTH DEPT.PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

b. COUNTY

Maryland

Prince George's

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

DOA

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hillside

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George General Hospital

d. STREET ADDRESS

5703 L St.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

James Edward O'Neil Sr.

4. DATE
OF
DEATH

Month

Day

Year

8

9

19

67

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

B. DATE OF BIRTH

6/15/13

9. AGE (In years
lost birthday)

54 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Engineer

10b. KIND OF BUSINESS OR
INDUSTRY

Bakery

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF WHAT
COUNTRY? U.S.A.

13. FATHER'S NAME

James O'Neil

14. MOTHER'S MAIDEN NAME

Ethel Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

054-03-8871

17. INFORMANT

Daughter
Joan E. O'Neil

Address

Same as Item #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary artery occlusion

INTERVAL BETWEEN
ONSET AND DEATH

minutes

Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.

DUE TO Arteriosclerotic heart disease

unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While ☐ Not While ☐
at work at work20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion
death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John Kehoe, M.D. Riverdale, Md.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED

8-9-67

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

8-12-67

23c. NAME OF CEMETERY OR CREMATORY

Nat. Mem. Pk. Cem.

23d. LOCATION (City or Town)

Falls Church, Va.

(County)

(State)

24. FUNERAL DIRECTOR

500 S. MAIN ADDRESS

W. H. Dorman Jr. Alex, Va.

25a. REC'D BY REGISTRAR

DATE

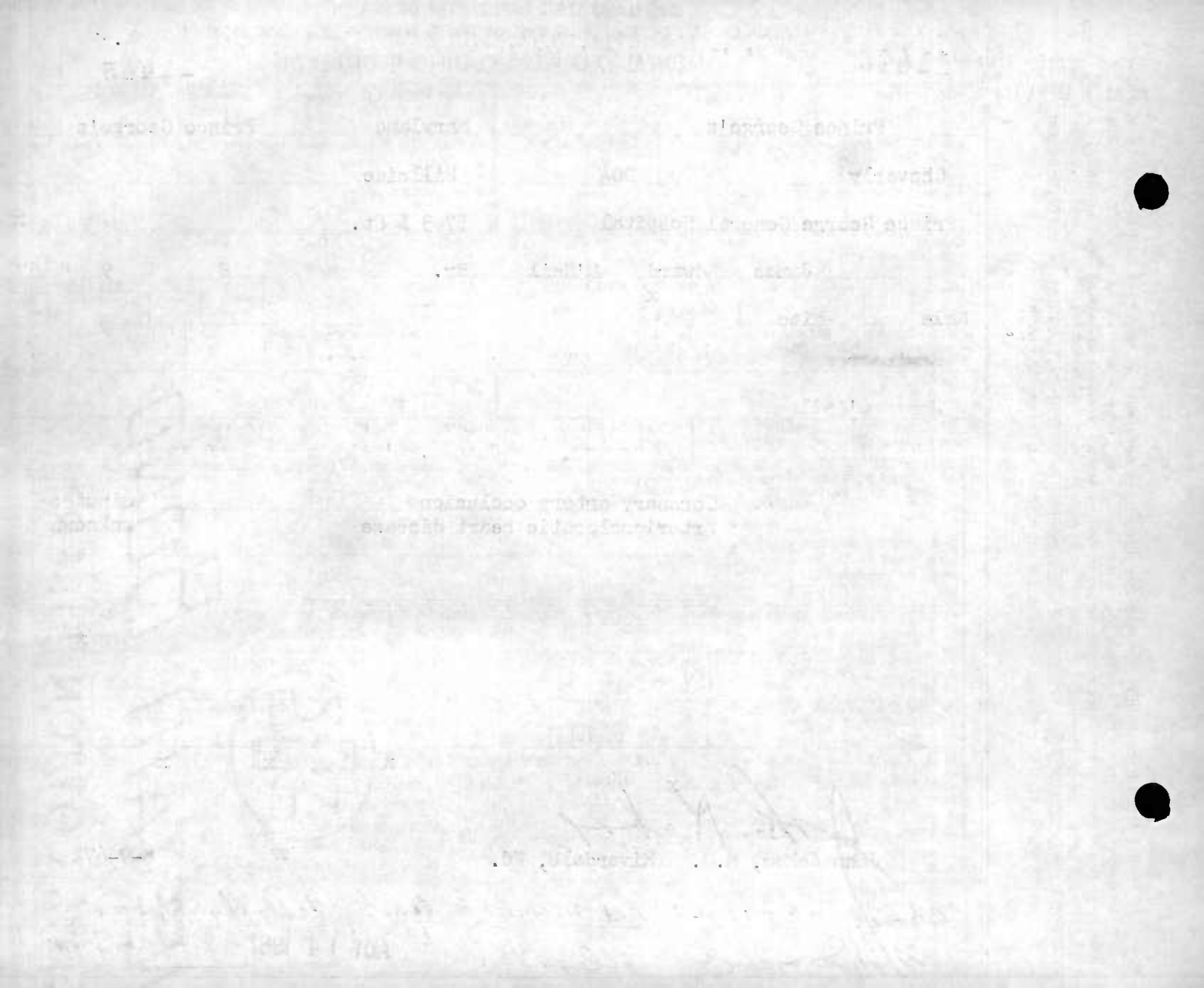
AUG 14 1967

25b. REGISTRAR'S SIGNATURE

James J. Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

11441

11446

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 6yrs. 10mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bell's Nursing Home		d. STREET ADDRESS 6403 Ager Road	
3. NAME OF DECEASED (Type or print) Ronnie Ottolina		4. DATE OF DEATH Month August Day 13 Year 1967	
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1957
9. AGE (In years lost birthday) yrs. 9		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) Venezuela		12. CITIZEN OF WHAT COUNTRY? Venezuela	
13. FATHER'S NAME Renny Ottolina		14. MOTHER'S MAIDEN NAME Renee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 1	
17. INFORMANT Bell's Nursing Home, Hyattsville, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X DUE TO ① CEREBRAL ALSY WITH SPASTICITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ② Brain damage, MARKED DUE TO ③ MICROCEPHALY (c) ③ MICROCEPHALY		INTERVAL BETWEEN ONSET AND DEATH since birth 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY , 19 65 , to AUG , 19 67 , that (I) (we) last saw the deceased alive on 1 AUG. 1967 , and that death occurred at 2:15 AM , from causes and on the date stated above.			
22a. SIGNATURE L.B. SNOW		22b. DATE SIGNED 8/14/67	
22c. PHYSICIAN'S NAME (Type) L.B. SNOW M.D.		22d. ADDRESS HYATTSVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 14, 1967	23c. NAME OF CEMETERY OR CREMATORY F. T. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor P.O. Md.
24. FUNERAL DIRECTOR F. Garck & Sons		25a. REG'D BY REGISTRAR AUG 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000 units

bravely

1000 units

bravely

bravely

bravely

bravely

bravely

1000 units

bravely

bravely

bravely

bravely

1000 units

bravely

bravely

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

1000 units

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

11442

11447

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 50 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 4404 Porter Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last James Sylvester Payne			4. DATE OF DEATH Month Day Year 8 26 19 67		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10 Oct. 1917		9. AGE (In years lost birthday) yrs. 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck-driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME George Payne			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes ww 2			14. MOTHER'S MAIDEN NAME SARIE A. GANTT		16. SOCIAL SECURITY NO.
17. INFORMANT George Payne			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 982X IMMEDIATE CAUSE (a) Penetrating stab wound of chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9:25pm 8-26- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Same as #2	
20f. (City or town) (County) (State) Baltimore Md		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		22. DATE SIGNED 8-28-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-31-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat	
23d. LOCATION (City or Town) (County) (State) Baltimore Md		24. FUNERAL DIRECTOR ADDRESS H.S. Washington & Sons 4925 Deane Avenue			
25a. REC'D BY REGISTRAR DATE SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 7, File 3392-8(2), 167 kk									
11443 CERTIFICATE OF DEATH 11448									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park 16-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 8209 Sherrill Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles O. Pennington					4. DATE OF DEATH Month August Day 19 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH august 15, 1913		9. AGE (In years lost birthday) yrs. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver			10b. KIND OF BUSINESS OR INDUSTRY Transportation			11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Pennington					14. MOTHER'S MAIDEN NAME Ann ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Lillian R. Pennington Same As # 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, secondary to 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute Anteroseptal Myocardial Infarction -DUE TO (c) Severe Upper GI bleeding.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from August 16, 19 67 , to Aug. 19, 19 67 , that (I) (we) last saw the deceased alive on August 19, 19 67 , and that death occurred at 4:00A M, from causes and on the date stated above.									
22a. SIGNATURE Therandym					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 8/19/67	
22c. PHYSICIAN'S NAME (Type) T. J. HERNANDEZ, MD					22d. ADDRESS PRINCE GEORGE'S Hospital.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/25/67		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery Suitland, P.G. Maryland			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland					25a. REC'D BY REGISTRAR DATE AUG 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

ASAC William H. ...
Robert E. ...
Washington ...
August 10, 1964

August 10, 1964
August 10, 1964

Joseph Pennington
Cap. Driver
Transportation
Tennessee
August 10, 1964

Charles
August 10, 1964
August 10, 1964

Prison George's General Hospital
Prison George's
Prison George's
Prison George's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 5 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.		47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 212 OAKWOOD STREET, SE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD CHARLES PETRINOVICH		4. DATE OF DEATH Month Day Year AUGUST 9 1967	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 28, 1911
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (County & State, or foreign country) Wardner, Idaho		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME NICKODEM PETRINOVICH		14. MOTHER'S MAIDEN NAME JUSTINA MARACHIC	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 518-01-3830	
17. INFORMANT 7514 DORRIS DR, SE		CHARLES LERCH-FRIEND-OKON, HILL, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO (b) VENTRICULAR TACHYCARDIA DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 12 HRS 6 MONTHS 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUGUST 4, 1967 , to AUGUST 9, 1967 , that (I) (we) last saw the deceased alive on AUGUST 9, 1967 , and that death occurred at 535 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>John F. Lindeman</i> M.D.		22b. DATE SIGNED AUGUST 9, 1967	
22c. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON, DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/14/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR DATE AUG 15 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	

100-100000

CRIMINAL RECORD

PRISON RECORD

WASHINGTON, D.C.

2 DAYS

ALL OTHERS

SIX MONTHS

ONE YEAR

100

AUGUST

SEPTEMBER

OCTOBER

NOVEMBER

DECEMBER

1911

1912

1913

1914

1915

1916

JUSTIN M. HARRIS

NICHOLAS P. HARRIS

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

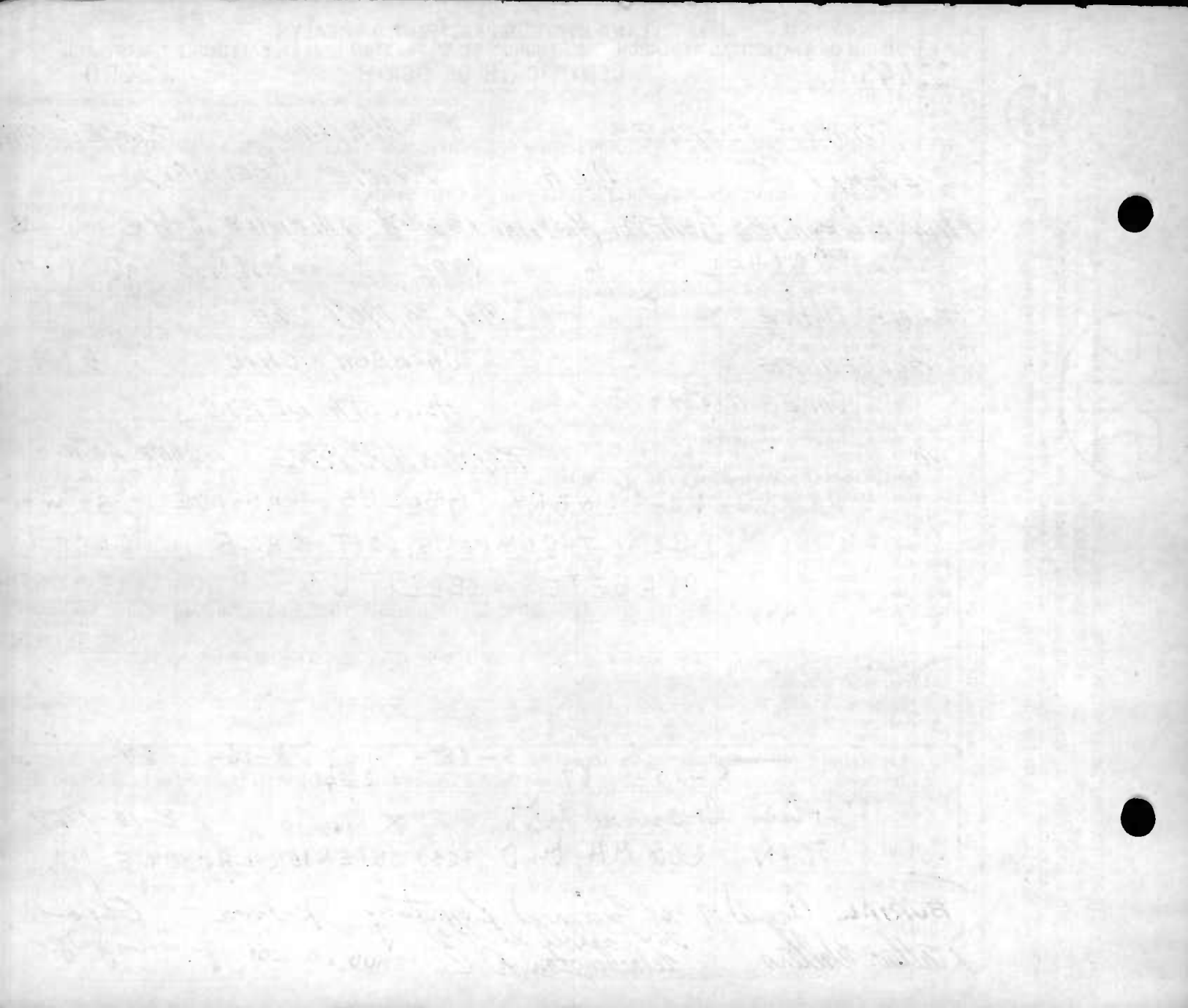
100-100000

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11445 11450											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN ID <u>H.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOWIE (BELAIRE)</u> 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES GENERAL HOSPITAL</u>						d. STREET ADDRESS <u>13328 IDEWILD DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RACHEL</u>		First <u>B.</u> Middle <u>POPE</u> Last		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>16</u> Year <u>1967</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 30, 1907</u>		9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>JACKSON, OHIO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES A. BARTON</u>						14. MOTHER'S MAIDEN NAME <u>AUGUSTA LEWIS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>RAYMOND R. POPE</u>		Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS, MASSIVE</u> 260X DUE TO (b) <u>PHLEBO-THROMBOSIS, LEFT CALF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>DIABETES MELLITUS</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>6 WEEKS</u> <u>13 MONTHS</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-15-</u> , 19 <u>67</u> , to <u>8-16-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-15-</u> , 19 <u>67</u> , and that death occurred at <u>2:45</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>John Cosma M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-16-1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN COSMA, M.D.</u>						22d. ADDRESS <u>3233 SUPERIOR LA. BOWIE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>August 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Jackson - Ohio</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>						ADDRESS <u>254 Carroll St N.W.</u> <u>Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 18 1967</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 5902 Cherrywood Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donald H. Potts		4. DATE OF DEATH Month August Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/39
9. AGE (In years lost birthday) yrs. 27		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Oliver Potts		14. MOTHER'S MAIDEN NAME Elizabeth T Thum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1958 to 1960		16. SOCIAL SECURITY NO. 188 30 2219	
17. INFORMANT Patricia F. Potts		Address Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Hepatitis with liver failure; DUE TO (b) lower gastro-intestinal hemorrhage DUE TO (c) 10 days		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 2, 1967 , to Aug. 2, 1967 , that (I) (we) last saw the deceased alive on Aug. 2, 1967 , and that death occurred at 8:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Hans Wodak		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Hans Wodak, M. D.		22d. ADDRESS Prof. Bldg. Centerway, Greenbelt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 5, 1967	23c. NAME OF CEMETERY OR CREMATOR Hillside cemetery	23d. LOCATION (City or Town) (County) (State) Roslyn Pa
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11447				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				301-5711					
1				CERTIFICATE OF DEATH				11452					
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Box 29, Route #3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Marie Middle B. Last Proctor				4. DATE OF DEATH Month Aug. Day 12, Year 19 67									
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23, 1914		9. AGE (In years lost birthday) yrs. 53		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Prinice George Co. Md.		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Joseph Robinson				14. MOTHER'S MAIDEN NAME Cora Pinkney				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph K. Proctor Rt. 3 - Box 298				Address Brandywine, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, bilateral DUE TO (b) Acute hepatic failure, due to DUE TO (c) Severe Liver Cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week year									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (he) (this hospital) attended the deceased from Aug. 9, 1967, to Aug. 12, 1967, that (he) (we) last saw the deceased alive on Aug. 12, 1967, and that death occurred at 11:20M, from causes on and on the date stated above.													
22a. SIGNATURE William B. Gunther				22b. DATE SIGNED 8/14/67									
22c. PHYSICIAN'S NAME (Type) William B. Gunther, M. D.				22d. ADDRESS Prince Georges General Hospital, Cheverly									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/67		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Ch. Cem.		23d. LOCATION (City or Town) (County) Brandywine, Md. Maryland							
24. FUNERAL DIRECTOR Martell Adams Aquinas Co, Md.				25a. REC'D BY REGISTRAR DATE AUG 18 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge							

STATE OF NEW YORK
JULY 1907

County of ...
City of ...
State of New York

That the undersigned, ...

do hereby certify that ...

Witness my hand and seal ...
this 12th day of July, 1907.

Attest: ...
Notary Public for the State of New York

Witness my hand and seal ...
this 12th day of July, 1907.

AUG 12 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

7-280168

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #11 info. taken from prev. birth cert. ph

CERTIFICATE OF DEATH

11448

11453

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. District of Columbia b. COUNTY n/a	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby		4. DATE OF DEATH August 26, 19 67	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1967	
9. AGE (In years lost birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cheverly, P.G. Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Shelton Reid		14. MOTHER'S MAIDEN NAME Franches Victoria McGutherie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776x IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) prematurely		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xx (this hospital) attended the deceased from Aug. 24, 1967 , to Aug. 26, 1967 , that 4 (we) last saw the deceased alive on Aug. 26, 1967 , and that death occurred at 1:25AM , from causes and on the date stated above.			
22a. SIGNATURE Harold J. Finck, M.D.		22b. DATE SIGNED Aug. 28, 1967	
22c. PHYSICIAN'S NAME (Type) Harold J. Finck, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9/2/67	
23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md.		25a. REC'D BY REGISTRAR SEP 6 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

IN STATE OF TEXAS

County of Tarrant

Washington

1122 South Avenue, W.

RETD

Civil

Aug. 2, 1967

James E. Sholton

James E. Sholton

James E. Sholton

[Handwritten signature]

Aug. 26, 67

Aug. 26, 67

Aug. 18, 1967

James E. Sholton

James E. Sholton

James E. Sholton

James E. Sholton

Aug. 26, 67

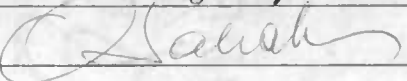
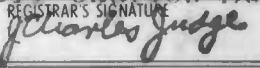
James E. Sholton

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11448

11454

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Rt 2 Box 56		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theodore A Rhinehart				4. DATE OF DEATH Month Aug. Day 23 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Oct., 1900	
9. AGE (In years last birthday) yrs. 66		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
13. FATHER'S NAME John Rhinehart		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-30-0460	
17. INFORMANT Mary B. Rhinehart		18. ADDRESS Rt. 2 Box 56 Accokeek, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer and Gangrene of the right lung; DUE TO (b) secondary to venous and arterial compression DUE TO (c) by tumor mass.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (was not present) attended the deceased from 1963 , 19 to Aug. 23, 1967 , that (I) (was not) saw the deceased alive on Aug. 23, 1967 , and that death occurred at 10.05 PM from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug. 24, 1967	
22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M. D.				22d. ADDRESS 6001 Landover Road, Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens Waldorf Charles Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Md.				25a. REC'D BY REGISTRAR DATE AUG 28 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11450			
CERTIFICATE OF DEATH			
11455			
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5705 Euclid Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys Middle Mae Last Riley		4. DATE OF DEATH Month Aug. Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/98 9. AGE (In years last birthday) yrs. 68-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Adjutant General Dept.	
11. BIRTHPLACE (County & State, or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austin Kirk Cramer		14. MOTHER'S MAIDEN NAME Florence Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-32-0296M	
17. INFORMANT Mrs. Robert Bennington Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Carcinoma of Left Breast DUE TO (c) Carcinoma of Left Breast 170X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 4-2 , 19 67 to Aug. 7 , 1967, that (I) (we) saw the deceased alive on Aug. 7 , 19 67 , and that death occurred at 11:30M , from causes and on the date stated above.			
22a. SIGNATURE Aaron Deitz		22b. DATE SIGNED 7 Aug 1967	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Aug 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR AUG 9 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

STATEMENT OF DEATH

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

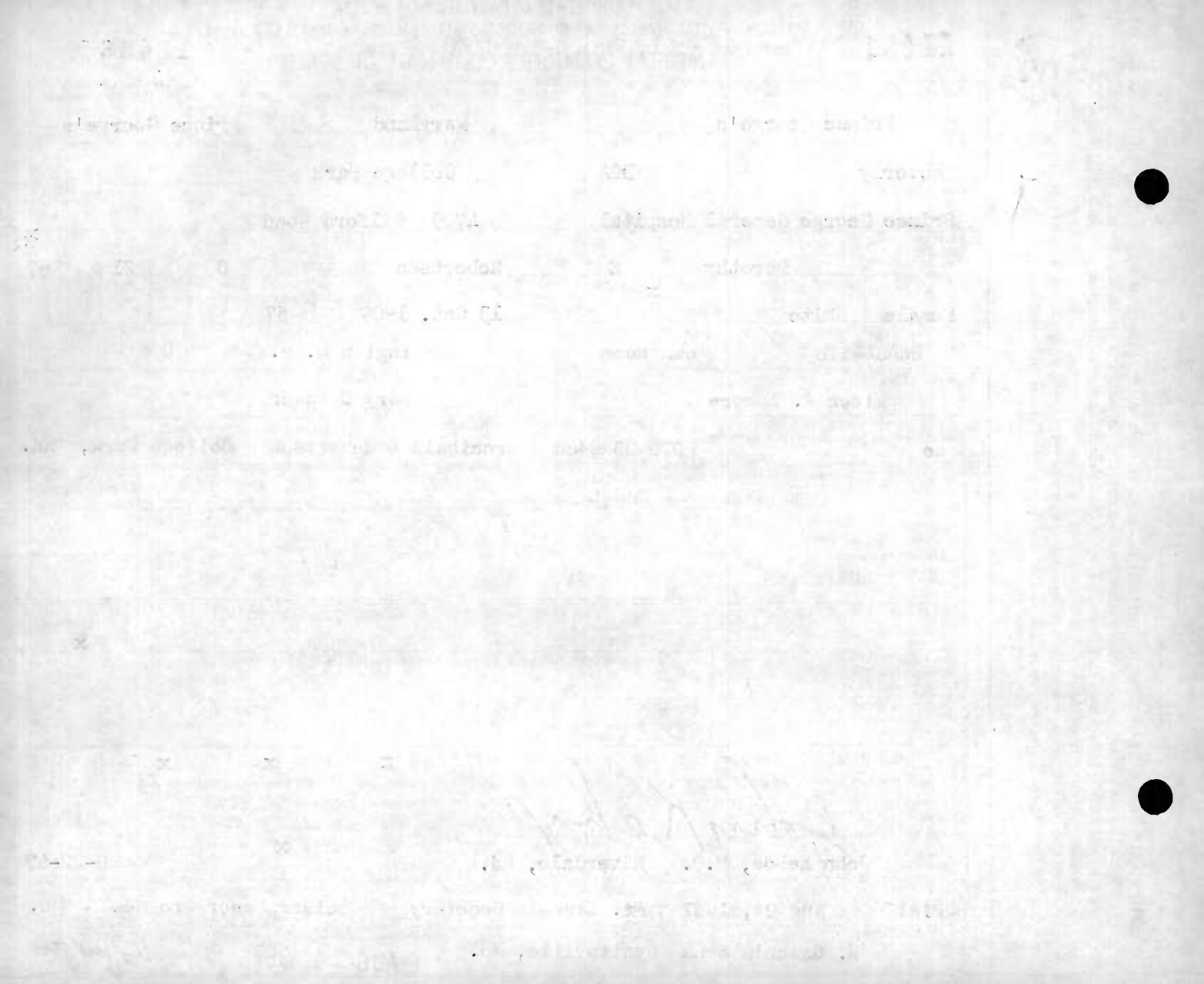
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11451

11456

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 4709 Gilford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Dorothy E Robertson			4. DATE OF DEATH Month 8 Day 21 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Oct. 1909		9. AGE (In years lost birthday) yrs. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington D. C.	
13. FATHER'S NAME Walter F. Lamore			14. MOTHER'S MAIDEN NAME Mary C Power		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 979 03 9488		17. INFORMANT Archibald L Robertson Address College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7955 IMMEDIATE CAUSE (a) Undetermined DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		22. DATE SIGNED 8-22-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR AUG 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

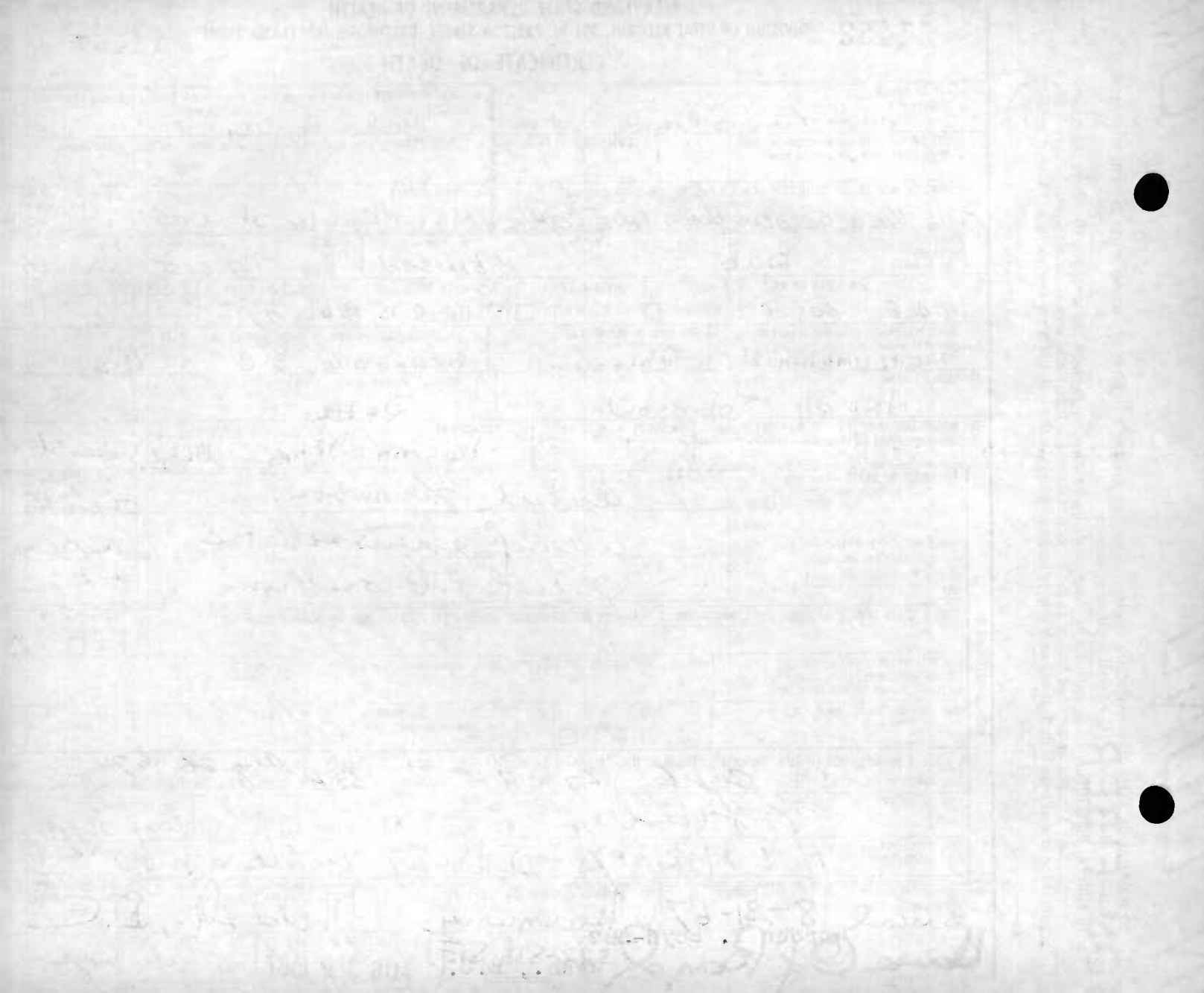


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW GARDENS HEALTH CARE CENTER</u>		d. STREET ADDRESS <u>4460 Douglas St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bub</u> Middle <u>Robinson</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Greenville, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRY Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Della</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Thelma Jones</u>		Address <u>4460 Douglas St. N.W. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u>general arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1967</u> to <u>Aug. 26, 1967</u> that (I) (we) last saw the deceased alive on <u>Aug 6, 1967</u> , and that death occurred at <u>5:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>H. G. HADLEY</u>		22b. DATE SIGNED <u>Aug 26/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. G. HADLEY MD</u>		22d. ADDRESS <u>4601 Nichols Ave NW Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawson</u>	23d. LOCATION (City or town) (County) (State) <u>Wash. D.C.</u>
24. FUNERAL DIRECTOR <u>Gordon T. Boyd - 522-8th St. Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



11453

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 6139 Oaklawn Road			
3. NAME OF DECEASED (Type or print) Andrew G Romjue				4. DATE OF DEATH Month 8 Day 14 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1897		9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) La Plata, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar L. Romjue				14. MOTHER'S MAIDEN NAME Maggie Carpenter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. I.		16. SOCIAL SECURITY NO.		17. INFORMANT Mary C. Romjue (Wife) Same as # 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self at home					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 6:30pm p.m. 8-14-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bedroom of home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 8-15-67					
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17-67		23c. NAME OF CEMETERY OR CREMATORY Washington, National Cemetery -		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR AUG 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

James G. Thompson

1904

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

James G. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #106 per telph. conv w/Gasch F.H.ph

CERTIFICATE OF DEATH

11454

11459

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 16 34 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum 16-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1514 Madison St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Winifred A. Sanker				4. DATE OF DEATH Month Day Year Aug. 18, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1893	
9. AGE (In years lost birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY A F I C I O		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME F J Sanker				14. MOTHER'S MAIDEN NAME Mary Little			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records Address Cheverly, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary malignant tumor of the brain 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 15, 1967 , to Aug. 18, 1967 , that (I) (we) last saw the deceased alive on Aug. 18, 1967 , and that death occurred at 2:45 PM from causes and on the date stated above.							
22a. SIGNATURE <i>Aaron Deitz</i>				22b. DATE SIGNED August 19, 1967		22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.	
22d. ADDRESS Prince George's Plaza, Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Wheaton Montgomery Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. RECEIVED BY REGISTRAR AUG 22 1967	
				25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>			

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL. 60637

Office of the President

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

11455

CERTIFICATE OF DEATH

11460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair c. LENGTH OF STAY IN 1b Belair		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12421 Shawmont Lane		d. STREET ADDRESS 12421 Shawmont Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIOLET MILSTEAD First Middle Last SCHULTZ		4. DATE OF DEATH Month Day Year August 21 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-1910 9. AGE (In years last birthday) yrs. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Milstead		14. MOTHER'S MAIDEN NAME Martha E. Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Mrs. Jacqueline Frederici		Address See Item No. 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Pancreas DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 157x			INTERVAL BETWEEN ONSET AND DEATH months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 67 to Aug , 19 67 , that (I) (we) last saw the deceased alive on Aug , 19 67 , and that death occurred at 7 A M, from causes and on the date stated above.			
22a. SIGNATURE Arnold Brody M.D.		22b. DATE SIGNED 21 Aug 67	
22c. PHYSICIAN'S NAME (Type) Arnold Brody, M. D.		22d. ADDRESS 3415 Hamilton St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 8-24-1967	23c. NAME OF CEMETERY OR CREMATORY Spencerville Methodist Church Cemetery	23d. LOCATION (City or Town) (County) (State) Spencerville, Md.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR DATE AUG 24 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	



Prince Georges

Belair

12421 Shawmont Lane

VICTOR KIRKLAND

BURNING

Female white 11-11-1910

Housewife

Married

Thomas H. Johnson

Married, Thompson

Mrs. Jacobson, Central No. 2

Arnold, Fred, N. Y.

12-24-1910

Joseph G. Grier, 1800, Washington, D.C.

AUG 1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

11456

11461

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Same as #2		d. STREET ADDRESS Box 14 E Contee Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Warren Shippe		4. DATE OF DEATH Month Day Year 8 11 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 April 1923
9. AGE (In years last birthday) yrs. 44		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY SANITARY COMM.	
11. BIRTHPLACE (State or foreign country) SAVAGE MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES LUTHER SHIPE		14. MOTHER'S MAIDEN NAME ANNA FRANCES KNISLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. BEVERLY SHIPE LAUREL MD.	
17. INFORMANT BEVERLY SHIPE LAUREL MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head with .38 cal automatic pistol.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:00 pm 8-11-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bedroom of home.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		22. DATE SIGNED 8-13-67	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/15/67	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cem	23d. LOCATION (City or Town) (County) (State) Colmar Manor Md
24. FUNERAL DIRECTOR DeWitt Dandeean, Laurel Md.		25a. REC'D BY REGISTRAR DATE AUG 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

100

100-100000

100

100-100000

100-100000

100

100

100-100000

100

100-100000

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

CERTIFICATE OF DEATH

11458

11463

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN lb 31 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens Health Care Center		d. STREET ADDRESS 5903 Old Silver Hill Rd.	
3. NAME OF DECEASED (Type or print) Elizabeth C. Sloan		4. DATE OF DEATH Month August Day 2 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-1-00
9. AGE (In years lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't Employee	
11. BIRTHPLACE (County & State, or foreign country) Johnstown, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Sloan		14. MOTHER'S MAIDEN NAME Margaret Brogan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli DUE TO (b) Hypertensive Pulmonary Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-1, 1967 , to 8-2, 1967 , that (I) (we) lost saw the deceased alive on 8-2, 1967 , and that death occurred at 6:30 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lapin M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Alfred R. Lapin, M.D.		22d. ADDRESS Clinton, Maryland 20735	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 8-5-67	23c. NAME OF CEMETERY OR CREMATORY Resurrection	23d. LOCATION (City or Town) (County) (State) Clinton, Md.
24. FUNERAL DIRECTOR Robert E. Wilhelm Fun. Home		25a. REC'D BY REGISTRAR AUG 7 1967	25b. REGISTRAR'S SIGNATURE James J. J...

UNITED STATES OF AMERICA

Clinton, IN.

Reconstruction

8-2-57

Robert E. Widdie, Jr., Home Address, IN.
4401 Bellingham

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and final event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11459

11464

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN 1b 48 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 5204 EDMERE COURT	
3. NAME OF DECEASED (Type or print) First Middle Last HAZEL LOUISE SMITH		4. DATE OF DEATH Month Day Year AUGUST 2 1967	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Feb 1926
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) CARROLL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E. DEWEY PICKETT		14. MOTHER'S MAIDEN NAME Bertha Lindsay	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT HUSBAND		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CARCINOMA-METASTATIC DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1 July 1966 , to 2 Aug 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2 August 1967 , and that death occurred at 2:45M , from causes and on the date stated above.			
22a. SIGNATURE <i>Nancy G. Culton Jr.</i>		22b. DATE SIGNED 2 August 67	
22c. PHYSICIAN'S NAME (Type) YANCEY G. CULTON, JR MAJ USAF Andrews AFB, Wash DC 20331		22d. ADDRESS USAF Hospital Andrews	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-4-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERANS AFFAIRS
WASHINGTON, D. C. 20460

STATEMENT OF DEATH

PRINCE GEORGE'S

ANDREW AFB

48 days

CAMP SPRING

USAF HOSPITAL ANDREWS

3204 EIGHTH STREET

WHITE

WHITE

WHITE

WHITE

2 FEB 1958

WHITE

WHITE

WHITE

CARROLL, HARRY

USA

WHITE

WHITE

HUSBAND

WHITE AS 42

WHITE

2 August 63

1 July 63

2 Aug 63

WHITE

2 August 63

USAF Hospital Andrews

WHITE, OR HAD USAF Hospital Andrews

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11465

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 5615 Hamilton Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Elmer Smith				4. DATE OF DEATH Month Day Year 8 1 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Aug. 1904		9. AGE (In years lost birthday) 62 yrs.	10. UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Clothing store		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Smith				14. MOTHER'S MAIDEN NAME Lena Frances Clayton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 05 5471		17. INFORMANT Address Mary Smith Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH minutes Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis - over 10 years.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 8-2-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE AUG 4 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11465

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN lb 5 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens.		d. STREET ADDRESS 5418 56th Ave apt 102	
3. NAME OF DECEASED (Type or print) Mae Teresa Smith		4. DATE OF DEATH Month 8 Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 84 yrs.
9. BIRTHPLACE (County & State, or foreign country) Monticello, Indiana		10. CITIZEN OF WHAT COUNTRY? United States	
11. FATHER'S NAME OLIVER S. DALE		12. MOTHER'S MAIDEN NAME ALICE E. BROWN	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. SOCIAL SECURITY NO. 062-10-9700A	
15. INFORMANT JAMES R. SHARMER		Address SAME AS #2	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4330 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Chacheexia DUE TO (c) Generalized and Cerebral Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 months 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-13 , 19 67 , to 8-29 , 19 67 that (I) (we) last saw the deceased alive on 8-29 19 67 , and that death occurred at 3:30 A.M., from causes and on the date stated above.			
22a. SIGNATURE E. Kooby		22b. DATESIGNED 8/29/67	
22c. PHYSICIAN'S NAME (Type) E. KOOPY		22d. ADDRESS PINE VIEW NURSING HOME CLINTON, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON, NATIONAL		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA.	
24. FUNERAL DIRECTOR W. W. Chambers Co Riverdale, MD		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

Bureau of Census, National Archives
E. K. Koozy
The New Virginia Home Clinton, MD

4
ALICE S. DAVE
JAMES R. SHERRILL, 2MAY 1942
ALICE E. BROWN

Formal Date
Was
Tolson Smith
8
81

Clinton
Page 1 of 1
1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11462

CERTIFICATE OF DEATH

12926

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Washington, D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 3 years 7 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 2010 Kalorama Rd., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Smith				4. DATE OF DEATH Month August Day 1 Year 1967			
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/08		9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State; or foreign country) Fla.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 250-10-5864		17. INFORMANT decendent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal bleeding DUE TO (b) Generalized arteriosclerosis DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peripheral vascular insufficiency with bilateral A-K amputations, left 6/8/67, right 7/20/67; recurrent cerebrovascular accidents, old.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/23/1963 , to 8/1/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/1/1967 , and that death occurred at 9:40 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/1/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/15/67		23c. NAME OF CEMETERY OR CREMATORY ANATOMICAL BOARD		23d. LOCATION (City or town) (County) (State) Washington, D. C. Bethesda	
24. FUNERAL DIRECTOR Earl F. Oufelt				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 15 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

Removal

Washington, D. C.

the name, N.D.

Glenn Dale Hospital, Glenn Dale, Md.

2/21/53

2/21/53

2/20/53; treatment cardiovascular accidents, ill.
2/20/53; treatment with bilateral A-V communications, late 2/8/53, time 10:00-10:15

Generalized arteriosclerosis

unknown

Massive gastrointestinal bleeding

10 yrs.

unknown

1950-10-1954

deceased

unknown

unknown

unknown

unknown

1951

1951

N

N

N

1/5/58

20

Maltese

Maltese

Agent 1

Prince George

Glenn Dale (1951)

2 years 1 mo. Washington, D. C.

Glenn Dale Hospital

2010 Kensington, N.W.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11463

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11467

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital		d. STREET ADDRESS 3316 Parktowne Rd. #34	
3. NAME OF DECEASED (Type or print) First Middle Last William Gwinn Smith		4. DATE OF DEATH Month Day Year 8 12 19 67	
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Oct., 1948
9. AGE (In years birthdate) 18 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR TO 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio	
11. BIRTHPLACE (State or foreign country) Louisville Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roy M. Smith		14. MOTHER'S MAIDEN NAME Erma B. Gwinn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212505975	
17. INFORMANT Mr. Roy M. Smith		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma-auto accident DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:00 pm 8-12-67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cedarville Rd.,	20f. (City or town) (County) (State) Brandywine, P.G. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		22. DATE SIGNED 8-13-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/ 18/67	
23c. NAME OF CEMETERY OR CREMATORY Restwood Memorial		23d. LOCATION (City or Town) (County) (State) Hinton, West Virginia	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214		25a. REC'D BY REGISTRAR AUG 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

• • •

37 10475 22 25

Appendix B-10

007017

1995

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

1110 4704 2

— — — — —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11464

CERTIFICATE OF DEATH

11468

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND c. LENGTH OF STAY IN lb 24 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4519 Banner St.	
3. NAME OF DECEASED (Type or print) William L. Smith		First Middle Last		4. DATE OF DEATH Aug. 4, 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/27/1914		9. AGE (In years last birthday) yrs. 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.	
13. FATHER'S NAME WILLIAM T. SMITH			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 212-14-5611		17. INFORMANT KATHERINE S. JONES
			Address 4675 BENNING, RD WASH., D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Portal cirrhosis of liver DUE TO (b) glucose Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 11, 19 67 , to Aug. 4, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 4, 19 67 , and that death occurred at 4:55 AM , from causes and on the date stated above.					
22a. SIGNATURE William B. Gunther		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Aug. 4, 1967	
22c. PHYSICIAN'S NAME (Type) William B. Gunther, M.D.		22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/8/67	23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION (City or Town) (County) (State) HIGHLAND PARK, MARYLAND	
24. FUNERAL DIRECTOR Robt. J. McQuire		ADDRESS 1820-9th St. N.W.		25a. REC'D BY REGISTRAR AUG 8 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

THE CENTRAL OF DEATH

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

Prison Records

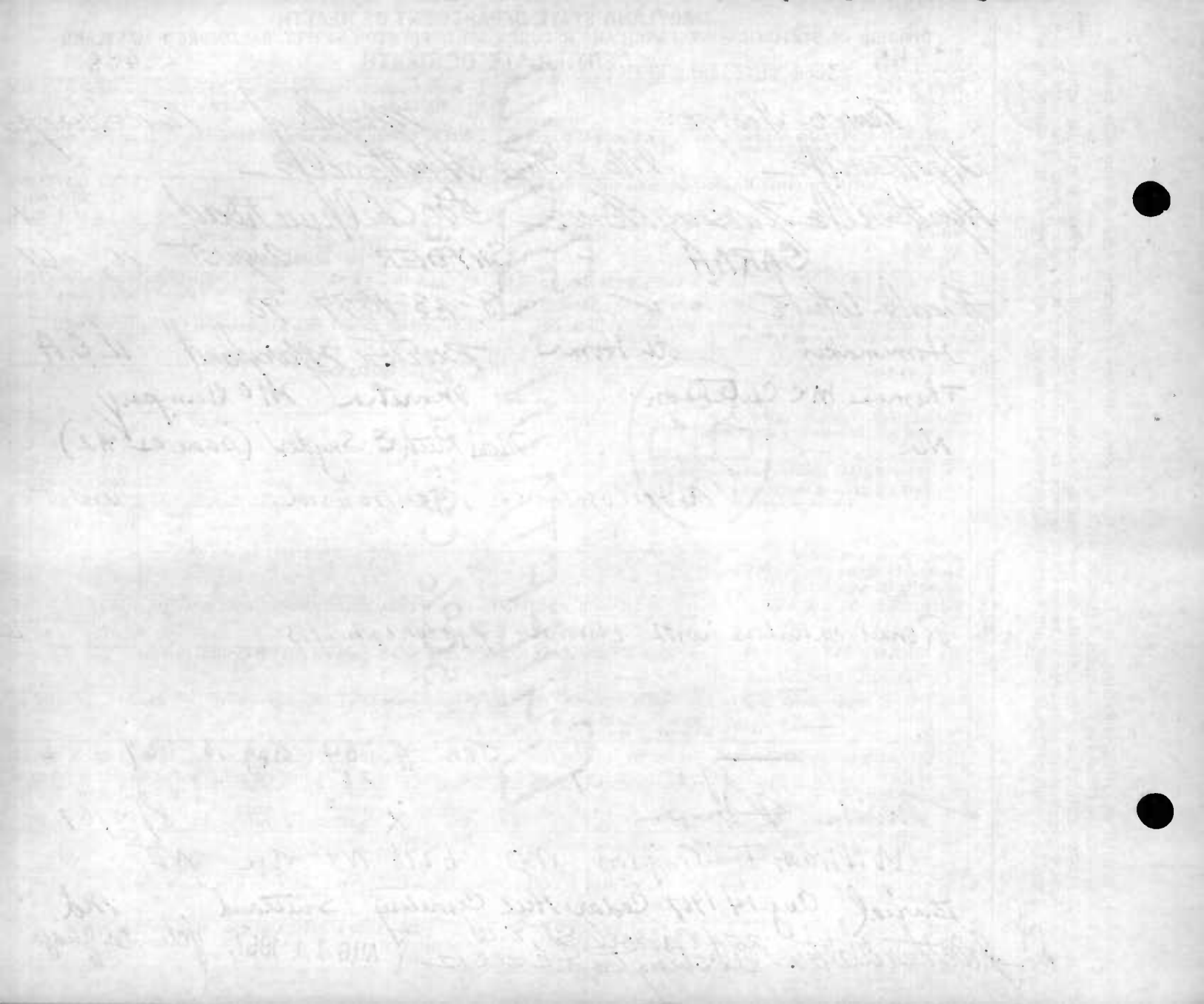
Prison Records

Prison Records

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11465				Item #8 Film #G391 5/16/67				11469			
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN 1b <i>4 Mo. 3 Days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hyattsville Nursing Home</i>						d. STREET ADDRESS <i>500 Chilpan Road</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>SARAH</i> First		Middle		Last <i>SNYDER</i>		4. DATE OF DEATH <i>August 10, 1967</i>		Month		Day Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1876 8-28-1876</i>		9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Barton Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thomas McCutcheon</i>						14. MOTHER'S MAIDEN NAME <i>Martha McCumsey</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Miss Ruth E. Snyder (same as #2)</i> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, generalized</i> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Renal calculus with chronic pyelonephritis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>under</i>	
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <i>Jan 9, 1964</i> to <i>Aug 10, 1967</i> , that (I) (we) last saw the deceased alive on <i>8/8</i> 1967, and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Martha McCumsey</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>8/10/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>William F. Simpson MD</i>						22d. ADDRESS <i>6216 N H Ave NE</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Aug. 14, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Switland Md.</i>				
24. FUNERAL DIRECTOR <i>Arthur Waters</i> ADDRESS <i>254 Carroll St. N.W. Washington, D.C. 20012</i>						25a. REC'D BY REGISTRAR <input checked="" type="checkbox"/>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
						DATE <i>AUG 14 1967</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 470

11466

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie (BelAir) Zip 20715	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE General Hospital		d. STREET ADDRESS 13209 Idlewild Drive	
3. NAME OF DECEASED (Type or print) First RICHARD Middle SOHL Last SOHL		4. DATE OF DEATH Month AUGUST Day 18 Year 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-09
10a. USUAL OCCUPATION (Give kind of work done during most of work life) Policeman		10b. KIND OF BUSINESS OR INDUSTRY New York City Police	9. AGE (In years last birthday) 58 yrs.
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Sohl		14. MOTHER'S MAIDEN NAME Gesine Kreutzner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 101-05-1790	
17. INFORMANT Mrs. Jeannette Sohl- #2		Address Same as Item	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT (HEMORRHAGE) DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) HYPERTENSIVE-ARTERIOSCLEROTIC C.V. DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 10 YEARS 23 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV. , 19 66 , to AUG. , 19 67 , that (I) (we) last saw the deceased alive on AUG. 18 , 19 67 , and that death occurred at 8:30 P. M, from causes and on the date stated above.			
22a. SIGNATURE John Cosma		22b. DATE SIGNED 8-18-67	
22c. PHYSICIAN'S NAME (Type) JOHN COSMA, M.D.		22d. ADDRESS 3233 SUPERIOR LA. BOWIE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/23/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Maspeth, N. Y.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR NOV 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

1959 following Drive
Boyle (Belair) 21p 2072

7-10-59
XXXX

General

U. S. A.

New York
City Police

Policeman

Charles Soli

Genius Abraham

101-0-1790 May. Telephone Soli-2

67 23/67 Mr. Oliver Connelly, New York, N. Y.

Michigan Ave. Upper Marlboro, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT

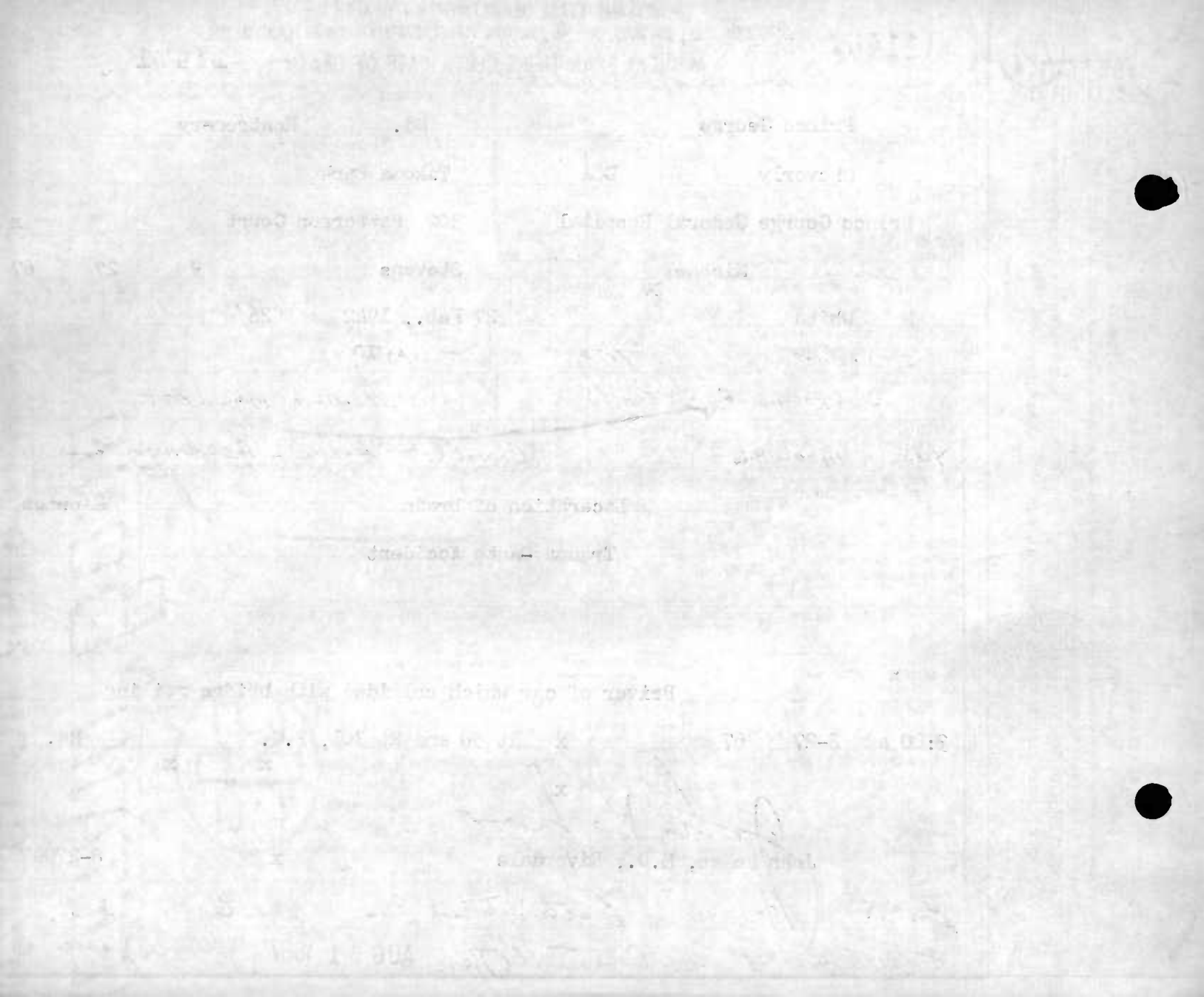
11467

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G392 9/5/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11471

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
3. NAME OF DECEASED (Type or print) Philip Michael Stevens		4. DATE OF DEATH 8 9 27 19 67	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Feb., 1942
9. AGE (In years lost birthday) 25 26 1/2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CARROLL G. STEVENS		14. MOTHER'S MAIDEN NAME VERONICA HACKETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1960-1965		16. SOCIAL SECURITY NO.	
17. INFORMANT Carroll G. Stevens - #3000000000		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 819.4 IMMEDIATE CAUSE (a) Laceration of brain DUE TO (b) Trauma Auto Accident DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which collided with bridge railing	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:00 am 8-27 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 50 and Rt 301, P.G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 8-27067	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-1-67	
23c. NAME OF CEMETERY OR CREMATORY Balt. National Cem.		23d. LOCATION (City or Town) (County) (State) Balt. Md.	
24. FUNERAL DIRECTOR John Funeral Home - Catonsville, Md.		25a. REC'D BY REGISTRAR AUG 31 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11468

CERTIFICATE OF DEATH

11472

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
c. LENGTH OF STAY IN 1b 3 days		d. STREET ADDRESS 9304 Rollingwood Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Stewart Bryan Stinson, Jr.		4. DATE OF DEATH Month Day Year August 9 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1935
9. AGE (In years lost birthday) 32 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic & Draftman	
11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stewart Bryan Stinson Sr.		14. MOTHER'S MAIDEN NAME Elizabeth Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 277 36 1224	
17. INFORMANT Mrs. Jane Kay Stinson		Address 5423 55th Pl Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Coronary Artery with Acute myocardial infraction. DUE TO (b) infraction. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/6, 19 67, to 8/9, 19 67, that (I) (we) last saw the deceased alive on 8/9, 19 67, and that death occurred at 6:50M. from causes on and on the date stated above.			
22a. SIGNATURE W. W. Chambers		22b. DATE SIGNED 8/9/67	
22c. PHYSICIAN'S NAME (Type) T. J. Hernandez, MD		22d. ADDRESS Prince George's Gen. Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		25a. REC'D BY REGISTRAR DATE AUG 14 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

三三

Richard, Virginia

A. B. C.

STEWART ELYAN STEINSON 31

Robert Williams

Mr. James Ray Station

BM, 314701R

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11469											
11473											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK. 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 415 ETHAN ALLEN AVENUE.						d. STREET ADDRESS 415 ETHAN ALLEN					
3. NAME OF DECEASED (Type or print) First FRANCES Middle U Last STRITE						4. DATE OF DEATH Month AUGUST Day 19 Year 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 6, 1874 93 yrs.		9. AGE (In years last birthday) Months Days Hours Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) HAGERSTOWN MD				12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN ULLRICH						14. MOTHER'S MAIDEN NAME MARY BRENNER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO. 579-03-2694		17. INFORMANT Address (SAME) DAUGHTER - MISS STRITE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERY THROMBOSIS 3324 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from JUNE , 1954, to 8/19 , 1967, that (I) (we) last saw the deceased alive on 8/19 , 1967, and that death occurred at 4:00 PM from the causes and on the date stated above.											
22a. SIGNATURE Lawrence A. Rapee						22b. DATE SIGNED 8/19/1967					
22c. PHYSICIAN'S NAME (Type) LAWRENCE A. RAPEE						22d. ADDRESS 1732 EYE ST NW WASH, DC					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF August 22-1967		23c. NAME OF CEMETERY OR CREMATORY St. Basil's				23d. LOCATION (City, town or county) (State) Washington Md.			
24. FUNERAL DIRECTOR Arthur Walters						25. REC'D BY REGISTRAR 254 Carroll St		25b. REGISTRAR'S SIGNATURE Charles J. J...			
						DATE AUG 22 1967					

PRINCE GEORGES

TAKOMA PARK

FRANCIS

FEMALE WHITE

HOUSE WIFE

JOHN ULLRICH

NO

MARYLAND PRINCE GEORGES

TAKOMA PARK

WIS ETHEL ALLEN

STREET WEST 19

June 6, 1974 93

MACKERSTOWN MD 020

MARY GREENBER (same)

279-02-281 daughter - was street

CEREBRAL ARTERY THROMBOSIS

GENERALIZED ASTERIOSCELOSIS

X

8/11/92

LAWRENCE A. RUMBLE 1935 EYE ST NW WASH, DC

X

8/11/92

8/11/92

8/11/92

8/11/92

8/11/92

8/11/92

CERTIFICATE OF DEATH

11470

11474

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b 3 Mos 9 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 1714 Otis St, NE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES LIGHTFORD SWARN First Middle Last			4. DATE OF DEATH AUGUST 22 1967 Month Day Year		
5. SEX MALE	6. COLOR OR RACE NEGROE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 June 1943	9. AGE (In years lost birthday) yrs. 24	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF	11. BIRTHPLACE (County & State, or foreign country) Plainfield, Indiana		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARCHEL L. SWARN			14. MOTHER'S MAIDEN NAME NANCY V. MITCHEM		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 309-44-2620	17. INFORMANT WIFE SAME AS #2 Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UREMIC MYOCARDOPATHY DUE TO (c) CHRONIC GLOMERULONEPHRITIS					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from 13 May , 19 67 , to 22 Aug , 19 67 , that he (we) last saw the deceased alive on 22 Aug , 19 67 , and that death occurred at 9:40 AM , from causes and on the date stated above.					
22a. SIGNATURE <i>John F. Lindeman</i>			22b. DATE SIGNED 22 Aug 67		
22c. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT USAF MC			22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Rem.	23b. DATE THEREOF 8/26/67	23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cem.	23d. LOCATION (City or Town) (County) (State) Plainsfield, Indiana		
24. FUNERAL DIRECTOR Falls Church Funeral Home Falls Church, Virginia <i>W. A. McDonald</i>			25a. REC'D BY REGISTRAR DATE AUG 25 1967		
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

W. A. Miller, Jr.
Talia Church, Indiana
Talia Church, Indiana

W. A. Miller, Jr. 8/25/67, Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

W. A. Miller, Jr. Talia Grove Cem.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11471

11475

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier	c. LENGTH OF STAY IN lb 10 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4402 32nd Street		d. STREET ADDRESS 4402 32nd Street	
3. NAME OF DECEASED (Type or print) Mary C. Tarafas		4. DATE OF DEATH Month August Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29 1920
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Joseph McNulty		14. MOTHER'S MAIDEN NAME Anno Brett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 203-09-7113	
17. INFORMANT Husband John Tarafas		18. ADDRESS 4402 32nd Street Mt Rainier, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) cardiovascular arteriosclerosis DUE TO (c) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 14, 1967 , to Aug 29, 1967 , that (I) (we) last saw the deceased alive on Aug 30 1967 , and that death occurred at 5:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Richard F. Shaw		22b. DATE SIGNED Aug 30 1967	
22c. PHYSICIAN'S NAME (Type) RICHARD F. SHAW		22d. ADDRESS 1324 Mich Ave NE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF (9-2-1967)	23c. NAME OF CEMETERY OR CREMATORY St Lawrence Church Cem.	23d. LOCATION (City or Town) (County) (State) Catasauqua, Pa.
24. FUNERAL DIRECTOR Nalley Funeral Home		25a. REC'D BY REGISTRAR SEP 5 1967	
ADDRESS Mt Rainier, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial

19. Signature of interment

20. Signature of cremation

21. Signature of disposition

22. Signature of final disposition

23. Signature of final disposition

24. Signature of final disposition

25. Signature of final disposition

26. Signature of final disposition

27. Signature of final disposition

28. Signature of final disposition

29. Signature of final disposition

30. Signature of final disposition

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
11472					CERTIFICATE OF DEATH					11476									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington b. COUNTY D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 2800 O St. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Frances P. Taylor					4. DATE OF DEATH Aug. 14 1967														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 May 1899		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Government					10b. KIND OF BUSINESS OR INDUSTRY Auditing					11. BIRTHPLACE (County & State, or foreign country) West Virginia					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Thomas E. Carson					14. MOTHER'S MAIDEN NAME Sarah Ann Miles														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. -					17. INFORMANT Harry A. Taylor, Sr.-husband					Address Same as #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Congestive Heart failure DUE TO (b) Rheumatic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3 Anemia - actual fibrillation										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 11 days , 19 67 , to 14 days , 19 67 , that (I) (we) last saw the deceased alive on 13 Aug , 19 67 , and that death occurred at 4:45 A.M. , from causes and on the date stated above.																			
22a. SIGNATURE Robert D. Dertz M.D.										22b. DATE SIGNED Aug 16 1967									
22c. PHYSICIAN'S NAME (Type) Robert D. Dertz M.D.										22d. ADDRESS Prince Georges PLAZA HYATTSVILLE Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 8-16-67					23c. NAME OF CEMETERY OR CREMATORY Nat. Memorial Park					23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia				
24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St. NE Wash.D.C.										25a. REC'D BY REGISTRAR DATE AUG 16 1967					25b. REGISTRAR'S SIGNATURE J. Charles Judge				

STATE OF TEXAS

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11477

11473

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 23 minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 5507 Sheriff Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Richard Terrell First Middle Last 4. DATE OF DEATH 8 13 19 67 Month Day Year		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1 May 1909 9. AGE (In years lost birthday) 58 yrs. IF UNDER 1 YEAR Months Days Hours Min. 10. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Gardener 10b. KIND OF BUSINESS OR INDUSTRY Beltsville Md. 11. BIRTHPLACE (State or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard V. Terrell 14. MOTHER'S MAIDEN NAME Virgy Terrell 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Melinda Lady. One N.W. Address 3318 Sherman			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-dural hematoma, bilateral DUE TO And multiple pelvic fractures (b) From trauma - auto accident DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8-13- 19 67 1:55am 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sheriff Rd. & Nash Rd. Prince George Co. 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 8-14-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Aug 19 1967 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park 23d. LOCATION (City or Town) (County) (State) Landover Md.		24. FUNERAL DIRECTOR Sharon + Helen + 4844 Le Ave NW ADDRESS 25a. REC'D BY REGISTRAR AUG 17 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

1-1-11
1-1-11
1-1-11

Prime George's
University
Prime George's
University

1-1-11
1-1-11
1-1-11

1-1-11
1-1-11
1-1-11

1-1-11
1-1-11
1-1-11

1-1-11
1-1-11
1-1-11

1-1-11
1-1-11
1-1-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11474

CERTIFICATE OF DEATH

11478

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4115 - 51st St., Apt. 201		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Everette Middle L. Last Thompson				4. DATE OF DEATH Month Aug. Day 22 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1943		9. AGE (In years last birthday) yrs. 24	IF UNDER 1 YEAR Months 22 Days 22 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Printing co.		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Thompson				14. MOTHER'S MAIDEN NAME Mary L Thompson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220 40 3405		17. INFORMANT Mary L Thompson Address Bladensburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Meningitis DUE TO (b) Lupus Erythematosus - generalized -asystemic DUE TO (c) 705.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xx (this hospital) attended the deceased from Aug. 2, 1967 to Aug. 22, 1967 , that xx (we) last saw the deceased alive on Aug. 22, 1967 , and that death occurred at 7:30 p.m. , from causes and on the date stated above.							
22a. SIGNATURE Roger B. Ingham				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Aug. 22, 1967	
22c. PHYSICIAN'S NAME (Type) Roger B. Ingham, M. D.				22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR AUG 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

415 - 21st St - 2nd Fl

2021.12.21 21:01

© 2000 Blackwell Science Ltd

Journal of Interpersonal Violence 28(12)

• 30A

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 8&21 Film 392 9-20-67 ams		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
11475		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY Prince George's's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfax	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In front of 3803 73rd. Avenue		d. STREET ADDRESS 3961 Perisimmon Drive	
3. NAME OF DECEASED (Type or print) Andrew Frank Toomes		4. DATE OF DEATH 8 2 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-1919
9. AGE (In years lost birthday) 47 yrs.		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		10b. KIND OF BUSINESS OR INDUSTRY U. S. Park Police Missouri	
11. FATHER'S NAME Andrew J. Toomes		12. MOTHER'S MAIDEN NAME Rosa Frank	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		14. SOCIAL SECURITY NO. 496-18-5208	
15. INFORMANT Mrs Beryl W. Toomes		Address Fairfax, Va.	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3222 DUE TO Intoxication Ethyl Alcohol		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 8-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/5/67	23c. NAME OF CEMETERY OR CREMATORY Portland Cemetery	23d. LOCATION (City or Town) (County) (State) Portland, Missouri
24. FUNERAL DIRECTOR C. M. West		25a. REC'D BY REGISTRAR AUG 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11476		11480	
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7449 80th Avenue	
3. NAME OF DECEASED (Type or print) First Argerit Middle Townshend Last 4. DATE OF DEATH Month August Day 9 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1878
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife XXX		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Washington Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Leary		14. MOTHER'S MAIDEN NAME Rebecca Crim	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ernest XXX Townshend College Park, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease (c) diagnose		INTERVAL BETWEEN ONSET AND DEATH 3 hours 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/9/60 , 19 60 , to 8/9 , 19 67 , that (I) (we) last saw the deceased alive on 7/28/67 , 19 67 , and that death occurred at 10:28 P.M. from causes on and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 8/9/67	
22c. PHYSICIAN'S NAME (Type) F.F. MUSSER		22d. ADDRESS 4410 74th Ave Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/12/67	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City or Town) (County) (State) Oakland Maryland	
24. FUNERAL DIRECTOR Gerald M. Minnick		25a. REC'D BY REGISTRAR AUG 17 1967	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE [Signature]	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-81 BY SP-6 JRS/STW

George Washington

Washington

George Washington

Washington

U.S.A.

Washington

Washington

George Washington

August 1

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11477				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH				11481			
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights d. STREET ADDRESS 5912 Pontiac St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				16-1							
3. NAME OF DECEASED (Type or print) First Mildred Middle Pauline Last Triesler				4. DATE OF DEATH Month Aug. Day 17, Year 1967											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/04		9. AGE (In years lost birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Maryland							
13. FATHER'S NAME Charles A. Sites				14. MOTHER'S MAIDEN NAME Fannie Cottroll											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 578-26-4712				17. INFORMANT Address Mr. A.W. Triesler (above address)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarct - Husband DUE TO (b) Coronary Artery Disease DUE TO (c) Cerebral Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Intestinal Obstruction sec to adhesions				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr 7 days 1 yr								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the deceased) attended the deceased from Aug. 13, 1967, to Aug. 17, 1967, that (I) (xx) saw the deceased alive on Aug. 17, 1967, and that death occurred at 2:18 PM , from causes and on the date stated above.															
22a. SIGNATURE George S. Banning, Jr.				22b. DATE SIGNED Aug. 18, 1967											
22c. PHYSICIAN'S NAME (Type) George S. Banning, Jr., M.D.				22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/21/67				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.				23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland				25a. REC'D BY REGISTRAR AUG 22 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

OFFICE OF THE SECRETARY OF THE ARMY

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

Princess Consort

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11482

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 11103 Cherry Hill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John Edward Tucker			4. DATE OF DEATH Month 8 Day 5 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 27 April 1913		9. AGE (In years lost birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY S. H. Kress		11. BIRTHPLACE (State or foreign country) Greene County, Mississippi	
13. FATHER'S NAME John Edward Tucker			14. MOTHER'S MAIDEN NAME Pauline Ball		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes 42-10 5091		17. INFORMANT Marion Lee Tucker	
			11103 Cherryhill Road Beltsville, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kenoe M.D.			22. DATE SIGNED 8-6-67		
EXAMINER'S NAME (Type) John Kenoe, M.D. Riverdale, Md.			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial-Trans Aug 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	
23d. LOCATION (City or Town) Birmingham, Alabama		23e. REC'D BY REGISTRAR AUG 9 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR C. Glen Carter 4434 Georgia Avenue Warner E. Humphrey, Inc. Silver Spring, Md.					

1953

Expenditures for the year ended December 31, 1953

General Administration

Salaries and Wages

Travel

Postage and Freight

Telephone

Supplies and Materials

Repairs and Maintenance

Insurance

Utilities

Depreciation

Other

Total

Income

Net Income

Balance Forward

Balance

Total

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11479

11483

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District Of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 3817 South Dakota Ave., N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vernor O. Tyler		4. DATE OF DEATH 8 23 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-1922
9. AGE (In years lost birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dayton Owens		14. MOTHER'S MAIDEN NAME Willie Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-22-847	
17. INFORMANT Mr. Grover Tyler		Address 3817 South Dakota Ave. NE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Laceration of brain			
DUE TO Compound skull fracture			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which collided with bridge abutment.	
20c. TIME OF INJURY Month, Day, Year 1:00pm 8-23-1967		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Balt. Wash. Parkway, Beltsville, Md.		20f. (City or town) (County) P.G. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 8-24-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BAM BUTLER INC/FUNERAL HOME		23b. DATE THEREOF 8/28/67	
23c. NAME OF CEMETERY OR CREMATORY LINCOLN		23d. LOCATION (City or town) (County) (State) MARYLAND	
24. FUNERAL HOME ADDRESS 8900 GEORGIA AVENUE, N. W.		25a. REC'D BY REGISTRAR AUG 29 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND

MEM

6/28/07 Lincoln

0

TO HOSPITAL, DIRECTOR OF HEALTH. The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11480
11484
11484
11484

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5911 37th AVE.</u>				d. STREET ADDRESS <u>5911-37th Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Lillie</u> Last <u>Viana</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 15, 1887</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Campbell Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Walter W. Martin</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-56-8219</u>			
17. INFORMANT <u>Mrs Kathryn Leatherwood</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>6 hrs.</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 21, 1967</u> to <u>Aug 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 21, 1967</u> , and that death occurred at <u>5911 37th Ave</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.H. Clements</u>				22b. DATE SIGNED <u>Aug 28 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.H. CLEMENTS</u>				22d. ADDRESS <u>6001-35th Ave Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CHURCH CEM.</u>		23d. LOCATION (City, town or county) (State) <u>LYNCHBURG, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Riverdale, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>AUG 28 1967</u>			

2007-08-09 15:18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tobacco papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11481

CERTIFICATE OF DEATH

11485

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 16-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor d. STREET ADDRESS 3802 Newton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William H. Warfield		4. DATE OF DEATH Month Aug. Day 4, Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/1878
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months 4, Days 4, Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leroy Warfield		14. MOTHER'S MAIDEN NAME Elvira Twining	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No - - -		16. SOCIAL SECURITY NO. 047-20-1969	
17. INFORMANT Evelyn R. Warfield- See Item No. 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary infarction DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 20, 19 67, to Aug. 4, 19 67, that (I) was saw the deceased alive on 8-4 19 67, and that death occurred at 5:52 A.M. from causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 8-4-67	
22c. PHYSICIAN'S NAME (Type) George Hageage, M. D.		22d. ADDRESS 3717- 38th Ave. Mt. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-7-1967	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Prince Georges Co. Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Joseph Lawler's Sons Inc 5130 Wisc. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR AUG 8 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

THE HISTORY OF DENNIS

Chowchewy

Colonial Manor

Prison Brothers General Hospital

Prison Brothers General Hospital

Wetland

Wetland

Wetland

Wetland

Wetland

Wetland

Wetland

Wetland

Wetland

July 20, 1987

July 20, 1987

1775-1987

1775-1987

1775-1987

11482

CERTIFICATE OF DEATH

11486

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 3 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		d. STREET ADDRESS 36 T Street, N.E.	
3. NAME OF DECEASED (Type or print) First Anna Mae Middle Scott Last Warner		4. DATE OF DEATH Month August Day 9 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Robert Scott		14. MOTHER'S MAIDEN NAME Annie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579-24-4417	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ENDOMETRIAL CARCINOMA (PRIMARY) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 1/2 MONTHS 5/9/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CACHEXIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/7 , 19 67 , to 8/7 , 19 67 , that (I) (we) last saw the deceased alive on 8/8 , 19 67 , and that death occurred at 1:03AM , from causes and on the date stated above.			
22a. SIGNATURE Charles M. Cabaniss		22b. DATE SIGNED 8/9/67	
22c. PHYSICIAN'S NAME (Type) CHARLES M. CABANISS, M.D.		22d. ADDRESS 2833 GEORGIA AVE. N.W.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF Aug. 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY Gates of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR John T. Rhines		25a. REC'D BY REGISTRAR W.E. DATE AUG 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NOTES AND CORRECTIONS

1964

0:30

2008 11 21 10:11

153

— 25 —

CERTIFICATE OF DEATH

11487

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5807 Sheriff Road	
3. NAME OF DECEASED (Type or print) Louise		4. DATE OF DEATH Month Aug. Day 19 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1912
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Spriggs		14. MOTHER'S MAIDEN NAME Nellie Hamilton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mildred Washington		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest Clinical. DUE TO (b) Nutritional cirrhosis of liver - severe DUE TO (c) Stroke		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 10, 1967, to Aug. 19, 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 19, 1967, and that death occurred at 4:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Roger B. Ingham M.D.		22b. DATE SIGNED Aug. 22, 1967	
22c. PHYSICIAN'S NAME (Type) Roger B. Ingham, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-24-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Bladensburg Rd. N.E.
24. FUNERAL DIRECTOR A.S. Washington & Son		25a. REC'D BY REGISTRAR 4925 Deane Ave	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 28 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Chapman, J. V.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (B)
6M 1/66

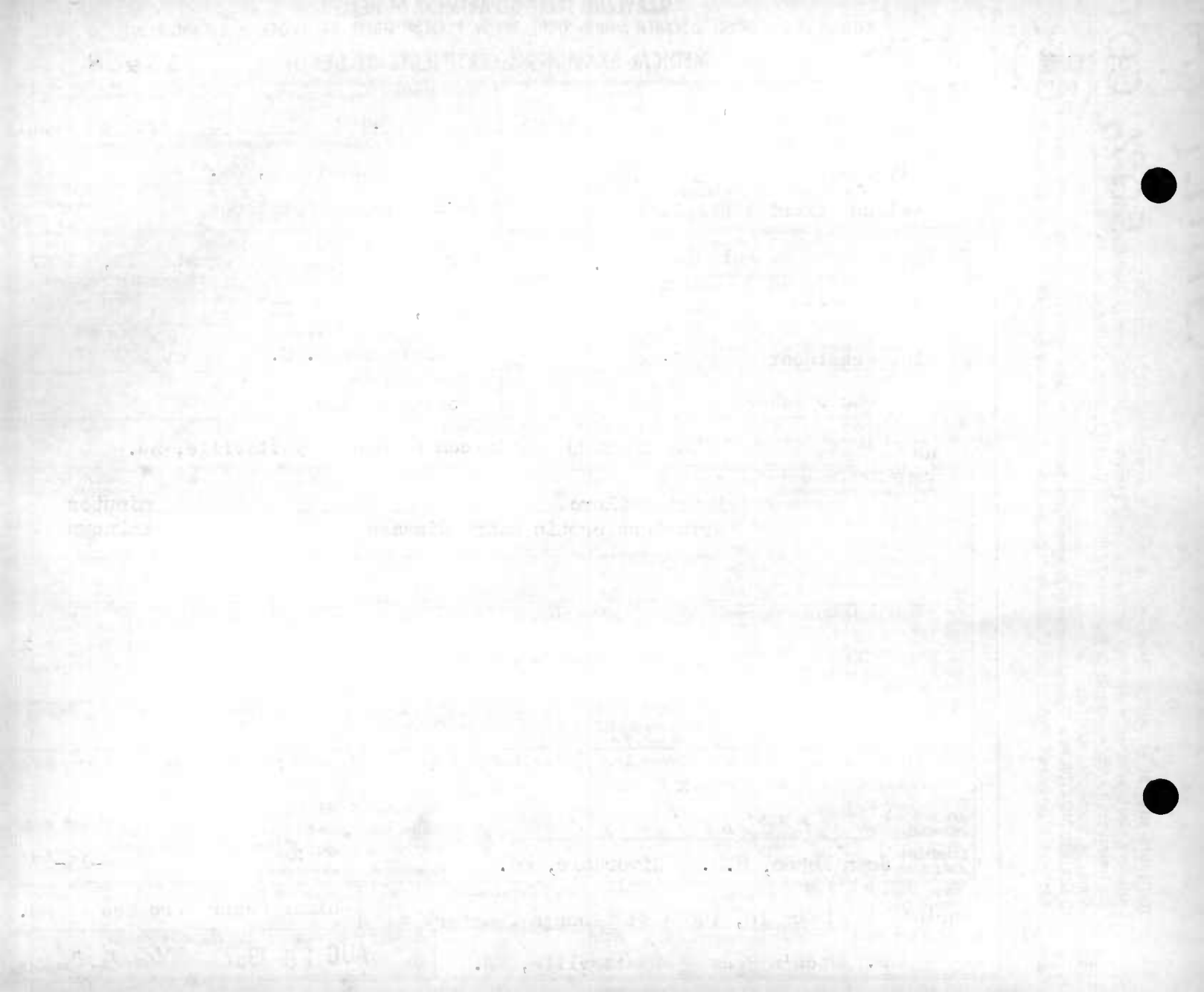
11484

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11488

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md b. COUNTY Pro Geo County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 4002 Queens Chapel Road	
3. NAME OF DECEASED (Type or print) First Dolphin Middle W. Last Weber		4. DATE OF DEATH Month August Day 12 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 31, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Vice President		10b. KIND OF BUSINESS OR INDUSTRY Bank	9. AGE (In years last birthday) yrs. 55
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Oscar Weber		14. MOTHER'S MAIDEN NAME Bertha Walker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 22 2099	
17. INFORMANT Kathleen P. Weber		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR AUG 16 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11485

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11489

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt 161	
c. LENGTH OF STAY IN lb DOA		d. STREET ADDRESS 7100 Hanover Parkway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Robert Weedon sr		4. DATE OF DEATH Month 8 Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Nov. 1911
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Payroll Dep't		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Andrew M Weedon		14. MOTHER'S MAIDEN NAME Maud G Railey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215 26 0062	
17. INFORMANT Leona F Weedon		Address Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 8-25-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 29 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 51
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11486

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11490

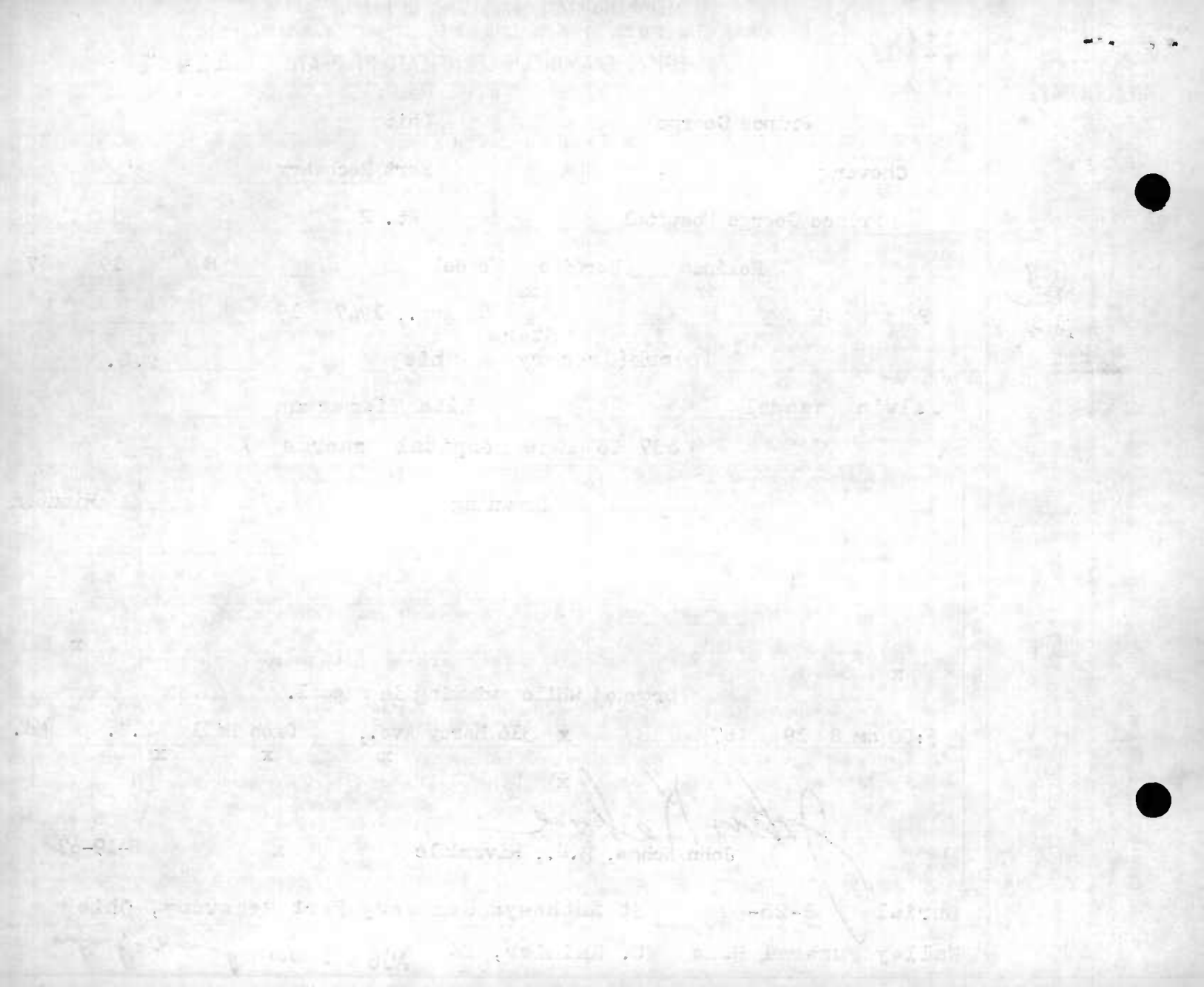
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 mo. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 5701 Longfellow Street			
3. NAME OF DECEASED (Type or print) Joseph P Welch				4. DATE OF DEATH Month 8 Day 2 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 June 1925		9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic		10b. KIND OF BUSINESS OR INDUSTRY engineer		11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Welch				14. MOTHER'S MAIDEN NAME Mary G (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 007 12 9779		17. INFORMANT Dorothy F. Welch		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adeno carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH over 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe				22. DATE SIGNED 8-3-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 4, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 4 1967	
						25b. REGISTRAR'S SIGNATURE Charles Juage	

MEDICAL CERTIFICATION

2. . J
FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						11491					
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Recovery 72-3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital						d. STREET ADDRESS Rt. 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Melinda Berdine Wendel						4. DATE OF DEATH Month Day Year 8 19 19 67					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Aug., 1947 19		9. AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Store Clerk (Grocery)		11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. EATHER'S NAME Melvin Wendel						14. MOTHER'S MAIDEN NAME Rita Timmerman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 307 46 1089		17. INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9294 IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH Minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in a pool.							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 5:00 am 8 19 19 67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 316 Marcy Ave.,		20f. (City or town) (County) (State) Oxon Hill P.G. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale						22. DATE SIGNED 8-19-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-23-67		23c. NAME OF CEMETERY OR CREMATORY St Anthonys Cemetery				23d. LOCATION (City or Town) (County) (State) Fort Recovery, Ohio	
24. FUNERAL DIRECTOR Nalley Funeral Home						ADDRESS Mt. Rainier, Md		25a. REC'D BY REGISTRAR AUG 22 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

4 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11488

CERTIFICATE OF DEATH

11482

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		d. STREET ADDRESS 1705 Columbia Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beverly June White		4. DATE OF DEATH Month August Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/32
9. AGE (In years lost birthday) yrs. 34 yrs.		10. IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (County & State, or foreign country) Scottdale, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest R. Smith		14. MOTHER'S MAIDEN NAME Evelyn Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 233-48-7058	
17. INFORMANT Lee Seibert White (Husband)		Address 1705 Columbia Avenue Landover, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) One Cardiac Arrest (Clinical) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease - Arteriolosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 27, 1967 to Aug 4, 1967 , that (I) (we) last saw the deceased alive on 5/14 1967 , and that death occurred at 8:23M , from causes and on the date stated above.			
22a. SIGNATURE Max M. Herzberg		22b. DATE SIGNED 8/11/67	
22c. PHYSICIAN'S NAME (Type) Dr. Max M. Herzberg		22d. ADDRESS 3308 Dodge Pk. Rd., Landover, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-14-1967	
23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION (City or Town) (County) (State) Martinsburg - Berkeley W. Va.	
24. FUNERAL DIRECTOR A. N. Brown Brown Funeral Home		25a. REC'D BY REGISTRAR AUG 14 1967	
ADDRESS Martinsburg, W. Va.		25b. REGISTRAR'S SIGNATURE Charles Judge	

CONFIDENTIAL OR DEATH

4-422

1705 Columbia Avenue
Baltimore, Maryland
Evelyn Brown
USA
Scottsdale, Pennsylvania
USA

531-48-7028 Lee Siefert White
(husband)
1705 Columbia Avenue
Baltimore, Maryland

Investigative Unit - Baltimore
One Captain Avenue (Baltimore)

U.S. Attorney
1705 Columbia Avenue
Baltimore, Maryland

2-1-1987
Baltimore County
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11489

CERTIFICATE OF DEATH

11493

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4212 Longfellow Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) XXXXX First Annie Middle E. Last Willis		4. DATE OF DEATH Month 8 Day 4 Year 19 67	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-72
9. AGE (In years last birthday) 95 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME A.G. Willis		14. MOTHER'S MAIDEN NAME Sara Gordon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216 12 4887	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 CONGESTIVE HEART FAILURE DUE TO (b) GEN. ARTERIOSCLEROSIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 9 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-26 , 19 67 , to 8-4 , 19 67 , that (I) (we) last saw the deceased alive on 8-3 , 19 67 , and that death occurred at 6:30 AM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 8-4-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

STATEMENT OF DEBIT

For the year ending

1911

George J. ...

...

...

...

...

...

...

...

...

...

...

...

AUG 1 1911

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is retained by the hospital or attending physician. Page 2 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11494

M

11490

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Georges c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Geo. Gen. Hosp.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchelville d. STREET ADDRESS RFD #1, Box 1018 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maggie M. Windsor First Middle Last			4. DATE OF DEATH Aug 15 1967 Month Day Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-93 Yrs. Months Days	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Hutchinson			14. MOTHER'S MAIDEN NAME Sarah Ridgeway		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. ---		
17. INFORMANT James A. Windsor-Same as Item #2.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE, ACUTE 5771 DUE TO Conditions, if any, which gave rise to immediate cause (b) Emphysema of Lungs (a), stating the underlying cause last. DUE TO (c) Syms PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1966 to 8/15/67, that (I) (we) last saw the deceased alive on 8/13/67, and that death occurred at 7:30 PM, from the causes and on the date stated above.					
22a. SIGNATURE Norman J. Comcau M.D.			22b. DATE SIGNED 8/15/67		
22c. PHYSICIAN'S NAME (Type) Norman J. Comcau			22d. ADDRESS 3503 Penny St NT Baltimore Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/19/67		23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery	
23d. LOCATION (City, town or county) Forestville		23e. (State) Md.		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.			25a. REC'D BY REGISTRAR AUG 21 1967		
25b. REGISTRAR'S SIGNATURE Charles Judge			25c. (Address)		

1-2-2

X

U. S. A.

Maryland

Own Home

Honolulu

Sarah Ridgeway

James Hutchinson

No

James A. Windsor-Same as Item 2.

MD.

Forestville

Epiphany Cemetery

8/10/57

Burial

Ridgeway Bros. Upper Marlboro, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11491

11495

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landham Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens</u>				d. STREET ADDRESS <u>6103 Base Street</u>			
3. NAME OF DECEASED (Type or print) <u>Georgia</u> First Middle Last <u>Woodruff</u>				4. DATE OF DEATH <u>August 7</u> 19 <u>67</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1887</u>	9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Leason Braune</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Caffey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Reba Woodruff</u> Address <u>Samuel St 2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-Respiratory Failure</u> DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>Aug 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 6</u> , 19 <u>67</u> , and that death occurred at <u>2:40 AM</u> , from causes on and the date stated above.							
22a. SIGNATURE <u>Max M. Herzberg</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8/7/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Max M. Herzberg</u>			22d. ADDRESS <u>3308 Dodge Park Rd Landover, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-10-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Redwood Hill, Md</u>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>Mattingly 131-11th St S.E. D.C.</u>			25a. REC'D BY REGISTRAR DATE <u>AUG 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Name of informant: [illegible]
6. Signature of informant: [illegible]
7. Date of report: [illegible]
8. Name of registrar: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Signature of informant: [illegible]
13. Date of report: [illegible]
14. Name of registrar: [illegible]
15. Signature of registrar: [illegible]
16. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

CERTIFICATE OF DEATH

11492

11496

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Conn. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fred		4. DATE OF DEATH Month August Day 25 Year 1967	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1929
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Sta. attendant		10b. KIND OF BUSINESS OR INDUSTRY garage	
11. BIRTHPLACE (County & State, or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fredman Worthy		14. MOTHER'S MAIDEN NAME d Le Anna Woods	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 430-52-3136	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage, massive DUE TO (b) sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pulmonary tuberculosis 12 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/16/1967 , to 8/25/67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/25/1967 , and that death occurred at 5:45AM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 8/25/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/30/67	23c. NAME OF CEMETERY OR CREMATORY Church	23d. LOCATION (City or Town) (County) (State) Wayne Arkansas
24. FUNERAL DIRECTOR Johnson & Jenkins 4804 So. Ave N.W.		25a. REC'D BY REGISTRAR SEP 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

Urban Data Hospital

55

22

13

14

• • •

○ 〇 〇 〇 〇 〇 〇

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

La Roche Woods

REF-20-000

◎譯

2162

1

01/23/07

• • • • •

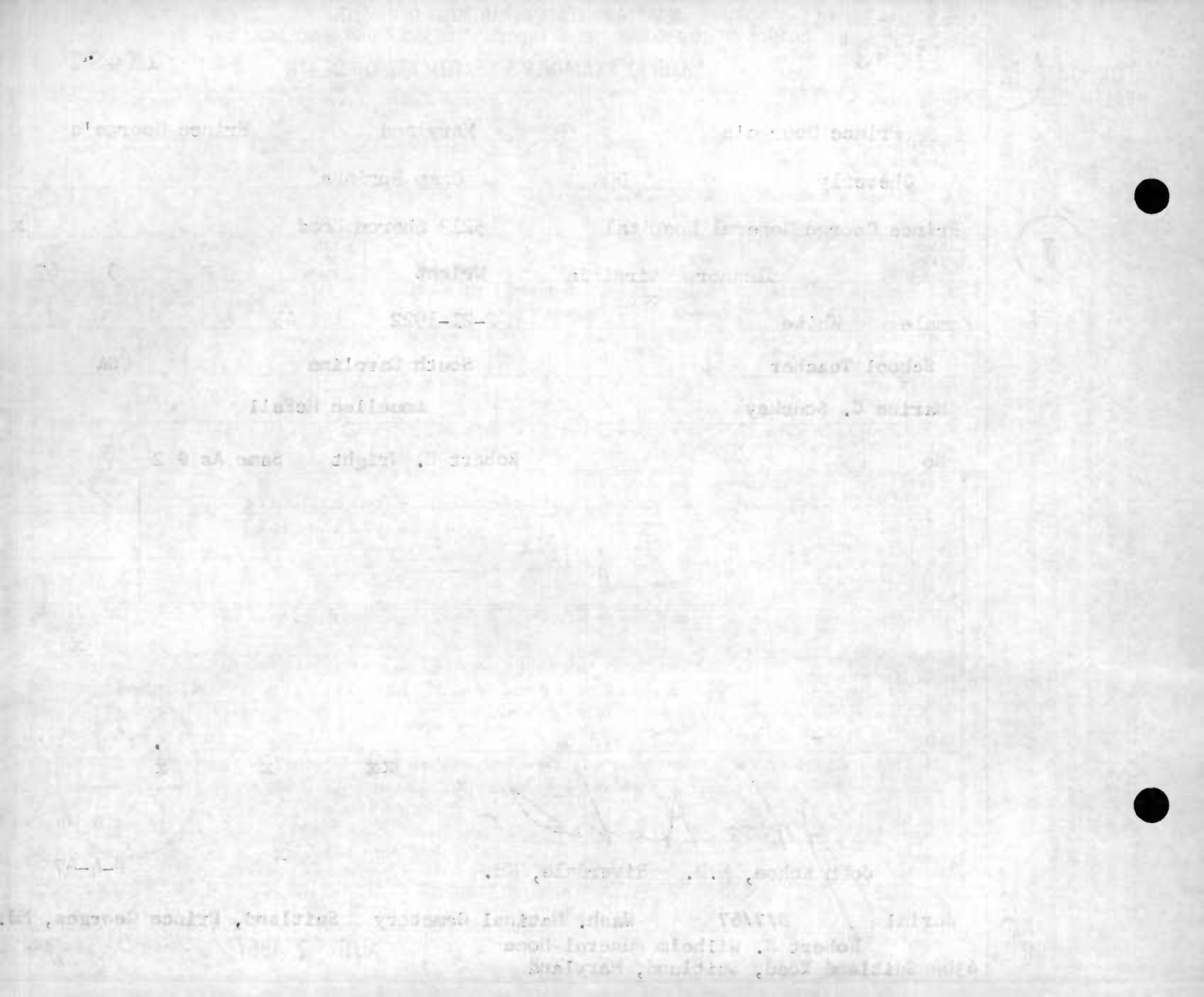
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11497

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eleanor Virginia Wright		4. DATE OF DEATH Month 8 Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) 45 yrs.
9. DATE OF BIRTH 2-21-1922		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marine C. Stuckey		14. MOTHER'S MAIDEN NAME Louellen McFall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert E. Wright		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Combined intoxication - barbiturate and ethyl alcohol DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested overdose of barbiturate and alcohol	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8-3 p.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Camp Springs P.G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 8-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/67	
23c. NAME OF CEMETERY OR CREMATORY Wash. Natinal Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home		25a. REC'D BY REGISTRAR AUG 7 1967	
4308 Suitland Road, Suitland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11494

CERTIFICATE OF DEATH

11498

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW CASTLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 1010 DUSHANE STREET	
3. NAME OF DECEASED (Type or print) ROBERT A YERGE		4. DATE OF DEATH Month AUGUST Day 27 Year 1967	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Aug 1936
9. AGE (In years last birthday) yrs. 31		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF	
11. BIRTHPLACE (County & State, or foreign country) DETROIT, MICHIGAN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM A. YERGE		14. MOTHER'S MAIDEN NAME DOROTHY A. COAPMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 364-34-4740	
17. INFORMANT Wife		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF RIGHT LUNG, METASTATIC DUE TO (c) 3 MOS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 3 August 1967 , to 27 August 1967 that he (we) last saw the deceased alive on 27 August 1967 , and that death occurred at 10:10 PM , from causes and on the date stated above.			
22a. SIGNATURE X David P. Campbell		22b. DATE SIGNED 27 Aug 67	
22c. PHYSICIAN'S NAME (Type) DAVID P. CAMPBELL, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Rem.	23b. DATE THEREOF Sept. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Roseland Park	23d. LOCATION (City or Town) (County) (State) Woodward. Michigan
24. FUNERAL DIRECTOR Falls Church Funeral Home		25a. REC'D BY REGISTRAR AUG 30 1967	
ADDRESS Falls Church, Virginia		25b. REGISTRAR'S SIGNATURE [Signature]	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

STATEMENT OF WITNESS

PENNSYLVANIA

NEW CASTLE

1030 HUGHES STREET

WITNESSES

DATE: 10/10/67

DEPARTMENT OF JUSTICE

HONORARY A. COOPER

DATE: 10/10/67

CRIMINAL RECORDS

RECORDS OF RIGHT LUNG, METASTATIC

10/10/67

10/10/67

10/10/67

UNITED STATES DEPARTMENT OF JUSTICE

JAMES E. CAMPBELL, CAPT USMC (Ret)

WASHINGTON

Department of Justice

Department of Justice

Department of Justice

Department of Justice

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11495

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11489

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 3407 42nd. Avenue			
3. NAME OF DECEASED (Type or print) Ruth Elizabeth Zimmerman				4. DATE OF DEATH Month 8 Day 21 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Oct. 1898		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Souders				14. MOTHER'S MAIDEN NAME Elizabeth Heagy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 05 7819		17. INFORMANT Address Wm H Zimmerman Colmar Manor, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 443 X DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 8-22-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE AUG 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Prison Book 10

Chesley

100

Robert Brown

Prison Book 10, 1000

1000, 1000

1000, 1000

1000, 1000

10

1000, 1000

1000, 1000

1000, 1000

10

1000, 1000

1000, 1000

1000, 1000

1000, 1000

1000, 1000

1000, 1000

1000, 1000

1000, 1000

1000, 1000